Congenital Heart Surgeons' Society Data Center: XXX-XXX FOLLOW-UP FORM YEAR 20XX

IDENTIFYING & PERSONAL HEALTH INFORMATION (PAGE 1&2) WILL BE STORED SEPARATELY FROM THE QUESTIONNAIRES AND KEPT PRIVATE & CONFIDENTIAL

Name:		
INFORMATION PREVIOUSLY GATHERED. PLEASE UPDATE OR CORRECT		
Name of Parent or Guardian:		
Current Address:		
Telephone Number:		
E-mail:		
Updated Address: (if applicable)		
Parent/Guardian Alternate Number:	☐ Mobile ☐ Work	Whose number is this?
Parent/Guardian Alternate Number:	☐ Mobile ☐ Work	Whose number is this?

Please list friends and/or relatives **NOT** living in your household that we may contact if we cannot locate you (e.g., change of address and/or telephone number).

When we contact them, we will ask them to provide us with your updated contact information (e.g., new address and/or telephone number) if they can.

NOTE: We will **NOT** be asking them to complete the follow-up form/questionnaires on your behalf.

You may provide up to 3 people:

Name ______________________________ Relationship ________________

Telephone Number: ________________ Mobile/Work Number: ________________

Name ______________________________ Relationship ________________

Telephone Number: ________________ Mobile/Work Number: ________________

Name ______________________________ Relationship ________________

Telephone Number: ________________ Mobile/Work Number: ________________

PLEASE COMPLETE BOTH SIDES OF THIS PAGE

PLEASE COMPLETE AND RETURN TO:

CHSS Data Center
The Hospital for Sick Children
555 University Ave., Rm. 4433, Black Wing
Toronto, ON M5G 1X8, Canada
Toll Free: 1-866-477-2477
Fax: (416) 813-8776

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HEALTHCARE PROVIDER CONTACT INFORMATION

Name of your child's Pediatric Cardiologist______________________________

Institution/Hospital Name______________________________

Street Address ______________________________

City, State/Province, ZIP/Postal Code ______________________________

Telephone Number: ____________________ Fax Number: ____________________

Name of your child's Pediatrician/ Family Doctor______________________________

Street Address ______________________________

City, State/Province, ZIP/Postal Code ______________________________

Telephone Number: ____________________ Fax Number: ____________________

1. Since **<DATE>**, has your child:

a) Had any **heart operations, catheterizations or "balloon"** procedures? YES ☐ NO ☐ If YES, please list

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	OPERATION/PROCEDURE
☐☐/☐☐/☐☐☐☐	__________	__________
☐☐/☐☐/☐☐☐☐	__________	__________

b) Had any **echocardiograms**? YES ☐ NO ☐ If YES, please include reason (e.g. routine follow up, because of symptoms, or other reason)

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	REASON
☐☐/☐☐/☐☐☐☐	__________	__________
☐☐/☐☐/☐☐☐☐	__________	__________

c) Been **hospitalized** for any other reason? YES ☐ NO ☐ If YES, please list reason

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	REASON
☐☐/☐☐/☐☐☐☐	__________	__________

I (parent/guardian name) __________________________________ give permission for the CHSS Data Center to obtain copies of medical reports relating to heart procedures on my child (name of child) _______________________________.
I understand that all the information provided will be kept confidential.

Signature: ____ Date Signed: ____________________________________

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PLEASE DO NOT WRITE YOUR NAME OR YOUR CHILD'S NAME ON THIS PAGE

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GENERAL QUESTIONNAIRE **DATE COMPLETED:** ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

1. How has your child's health been over the past year?

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Child's current **height** ________________ and **weight** ________________

3. List all of your child's current medications: ________________________________

4. Does your child have an artificial heart pacemaker? YES ☐ NO☐

   If YES, date of first placement: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY)

5. During the past year, has your child had any of the following symptoms?

   a. Chest Pain YES ☐ NO ☐

   b. Fainting YES ☐ NO ☐

   c. Palpitations YES ☐ NO ☐

6. Please complete the attached questionnaires: PedsQL™ [and Conditions and Problems Questionnaire (CHSS Data Center)].
   (**PLEASE DO NOT WRITE YOUR NAME OR YOUR CHILD'S NAME ON THE QUESTIONNAIRES**)

Thank you very much for your participation. Is there any additional information you want to share with us about your child's health?

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STUDY #:

STUDY # will be indicated by CHSS Data Center upon receipt of this completed page/form

FOLLOW-UP #: