

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:	<input type="checkbox"/> Mobile <input type="checkbox"/> Work	Whose number is this?
Parent/Guardian Alternate Number:	<input type="checkbox"/> Mobile <input type="checkbox"/> 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 your child's last **CHSS Data Center follow up <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
<input type="text"/>	_____	_____
<input type="text"/>	_____	_____

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
<input type="text"/>	_____	_____
<input type="text"/>	_____	_____

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

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	REASON
<input type="text"/>	_____	_____

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