TERIFLUNOMIDE Exposure Targeted Follow-Up Checklist
INFANT STATUS (1-week post delivery, 6, 12, 24 Months)

Date of Report: _____
Patient I.D.: _____
Age of infant: _____months

Infant Status
☐ Living, no medical or developmental problems, or any possible congenital abnormalities
☐ Living with suspected or diagnosed medical complications, developmental problems, or congenital abnormalities
☐ Deceased, date or age at death _____Cause of death _____
(Please provide autopsy report if available)
Infant Measurements:
Date of measurement: (DD/MM/YYYY)
Height: ☐ cm ☐ in
Weight: ☐ kg ☐ lb
Head circumference: ☐ cm ☐ in

Infant Medical History
1. Has the infant experienced serious infection requiring hospitalization? ☐ Yes (describe below) ☐ No ☐ Unknown *If yes, please specify the infection (site, organ) treatment and outcome:*
2. Is there evidence the infant is immunocompromised? ☐ Yes (describe below) ☐ No ☐ Unknown *If yes, please describe:*
3. Has the infant had other relevant illness, surgeries or hospitalizations? ☐ Yes (describe below) ☐ No ☐ Unknown *If yes, please specify illness (diagnosis), when it began, treatment and outcome:*

Infant Diet

☐ Breastfed
☐ Weaned
☐ Feedings in addition to breast milk (describe: _____)
☐Solids (description of diet: _____)

Developmental History (to be completed at 1-week post delivery, 6 months, 12 months, and 24 months)

Has the infant shown any evidence of developmental delay? ☐ Yes ☐ No ☐ Unknown

If yes, please specify:
☐ *Motor development Language development* ☐ *Social/emotional development*
☐ *Delay is noted, diagnosis is unknown* ☐ *Other, please describe*

Relevant Laboratory Tests or Procedures

Date	Test / Procedure	Results

Infant Milestones

Milestone	**Date/ Age**	**Comments**
Rolled over		
Reached for objects		
Sat up without support		
Turned to locate a voice		
Said first word		
Stood alone		
Early sentence construction		

Reporter Information	
Name:	Title:
Contact address:	Institution:
	Department:
	Phone:
E-mail:	Fax:
Healthcare professional: ☐ Yes ☐ No	If yes, please specify occupation:

Completed By		
Name:	Signature:	Date (DD/MMM/YYYY):