

Date: November 25, 2021

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

Patient ID: _____

Date of Report: _____

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 inWeight: kg lbHead 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, 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: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Country: _____

Institution: _____ Department: _____

Phone: _____ Fax: _____ E- mail: _____

Healthcare professional: Yes No If yes, please specify occupation: