YORKSHIRE & HUMBERSIDE HAEMATOLOGY NETWORK

Study Number

Parent's questionnaire

Instructions

1. Please write clearly and if choices are given, tick the appropriate box.

2. If you need more space you can continue on the back page

3. If you have any questions or need help filling in this form, please contact us on our freephone number:

   0800 328 0655

4. Once you have completed the questionnaire, please return it in the stamped addressed envelope provided to:

   YHHN
   Area 3 Seebohm Rowntree Building
   Dept Health Sciences, University of York
   Heslington, York
   YO10 5DD

1. Please write your child's address, postcode and date of birth in the box below, or if there is a sticker, check that the details are correct. If there are any mistakes, please write changes in the box on the right.

Address	Amended Details
Date of birth (dd/mm/yy)	Date of birth (dd/mm/yy)

2. Please write the name, address and telephone number of your child's general practitioner (GP) in the box below.

GP name

GP address

Postcode

Telephone

3. Please can you tell us:

Your name

Your relationship to the child (e.g. mother/ father/ guardian)

4. This section is about your child's birth and early days

a) please can you tell us where your child was born?

hospital name and place

b) what was your baby's birth weight?

grams (g)

pounds (lb) ounces (oz)

c) was your baby admitted to special or intensive care unit after birth? YES NO

if yes, why was this?

(for office use)

d) did your baby have any illness or abnormality noted at birth or shortly afterwards? YES NO

if yes, what was this?

(for office use)

e) was your baby kept in hospital for any reason? YES NO

if yes, what was this?

(for office use)

4. This section is about the diagnosis of your child's blood disorder

a) did your child have any symptoms before he or she was diagnosed with a blood disorder? YES ☐ NO ☐

if yes, what were the first symptoms of your child's illness and when approximately did you or your child first notice them?

symptom		date (dd/mm/yy)	
symptom		date (dd/mm/yy)	
symptom		date (dd/mm/yy)	
symptom		date (dd/mm/yy)	
symptom		date (dd/mm/yy)	

b) when did you first seek medical advice? date (dd/mm/yy)

c) who did you first seek advice from? (e.g. GP, health visitor, NHS direct etc)

d) what diagnosis was made at this time?

		(for office use)
diagnosis 1		
diagnosis 2		
diagnosis 3		

e) when was your child first referred to a hospital or specialist for further investigation? date (dd/mm/yy)

who was your child referred to?

f) if there is anything else you would like to tell us about the diagnosis of your child's blood disorder, please use this space:

6. This section is about any other illnesses or conditions your child has/ has ever had

a) has your child ever had any other illnesses or conditions needing regular visits to clinics or hospitals YES ☐ NO ☐

if yes, why was this?

				(for office use)
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		

b) has your child ever been admitted to hospital for any other reason? YES ☐ NO ☐

if yes, why was this?

				(for office use)
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		
reason		date (dd/mm/yy)		

c) have you, or anyone else, ever had any concerns about your child's development? (e.g. sitting up, walking, speech, learning difficulties etc) YES ☐ NO ☐

if yes, why was this?

please use this space to tell us anything else you or your child would like us to know

thank you for completing this questionnaire

Please return the completed questionnaire in the prepaid envelope provided to:

YHHN
Area 3 Seebohm Rowntree Building
Dept Health Sciences, University of York
Heslington, York
YO10 5DD

freephone: 0800 328 0655

website: www.yhhn.org

email: enquiries@yhhn.org

LEUKAEMIA & LYMPHOMA RESEARCH

Beating Blood Cancers