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 ☐ 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, 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:**