SINEPOST

SARS-CoV-2 infection in neonates or in pregnancy: Outcomes at 18 months

Health Care Contacts

1. Has your child been admitted to hospital as an in-patient **since they were born**? If they were admitted to the neonatal unit soon after birth please **do not** count this admission.
(*Please tick yes or no*)

Yes ☐ No ☐

If yes, please give the reason for **each** in-patient hospital admission and the number of nights spent in hospital in the table below

In-patient admission	**Reason for hospital in-patient admission**	**Number of nights spent in hospital**
1		
2		
3		
4		
5		
6		

If your child had more than six admissions, please provide details in the free text box on page 4.

2. Has your child been admitted to hospital as a day patient **since they were born**? This may have been for an operation or an investigation such as a scan where they **did not** need to spend the night in hospital. (*Please tick yes or no*)

Yes ☐ No ☐

If yes, please give the reason for **each** day patient hospital admission in the table below

Day patient admission	**Reason for hospital day patient admission**
1	
2	
3	
4	
5	
6	

3. Has your child visited hospital for any of the following **since they were born**? (*please tick yes or no for all, and add total number of visits if yes)*

Type of visit	**Please tick**	**Total number of visits**
Outpatient clinic visit (eg. Paediatrician)	Yes ☐ No ☐	
Accident and Emergency department visit	Yes ☐ No ☐	
Other – please specify _____	Yes ☐ No ☐	

4. **Apart from** the routine health checks offered to all young children, has your child seen any of the following community professionals as a result of any other concerns **in the past 6 months?** (*Please indicate yes or no for all, and add total number of visits if yes*)

Community Professional	**Please tick**	**Total number of visits**
General Practitioner (GP)	Yes ☐ No ☐	
Health Visitor	Yes ☐ No ☐	
Practice Nurse	Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☐	
Home visitor / volunteer	Yes ☐ No ☐	
Community children's doctor (Paediatrician)	Yes ☐ No ☐	
Physiotherapist	Yes ☐ No ☐	
Occupational Therapist	Yes ☐ No ☐	
Social Worker	Yes ☐ No ☐	
Optician	Yes ☐ No ☐	
Speech and Language therapist	Yes ☐ No ☐	
Dietitian	Yes ☐ No ☐	
Other – please specify _____	Yes ☐ No ☐	

Woodward K, *et al. BMJ Paediatrics Open* 2022; 6:e001571. doi: 10.1136/bmjpo-2022-001571

Personal Financial Costs

1. **Since your child was born** have you and/or partner had any additional personal financial costs **because of your child's health**? (*please tick all*)

Examples of costs to you	**Please tick**	**If yes, please give approximate total spent in £**	**Please give details**
Have you purchased special equipment?	Yes ☐ No ☐		
Have you made changes to your home because of your child's health?	Yes ☐ No ☐		
Have you paid excessively for travel and/or parking because of hospital or outpatient visits?	Yes ☐ No ☐		
Other – please specify	Yes ☐ No ☐		

2. **Since your child was born** have you and/or your partner had any time off work **as a result of your child's health**? (Please **do not** include time when you were on maternity/ paternity leave)

	You	**Your partner**
Have you and/or your partner taken time off work (**without pay**)?	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, how many days have you taken off work	Days off work _____	Days off work _____
Have you and/or your partner taken time off work (**with pay**)?	Yes ☐ No ☐	Yes ☐ No ☐
If Yes, how many days have you taken off work	Days off work _____	Days off work _____

3. **Which of these best describes your current situation?** *(Please tick **only one** box in each column. If you are on maternity/paternity leave, please report what you expect your status to be when this leave ends)*

You	**Your partner**
In paid work full-time ☐	In paid work full-time ☐
In paid work part-time ☐	In paid work part-time ☐
At home looking after my family or dependents ☐	At home looking after my family or dependents ☐
In education ☐	In education ☐
Unemployed ☐	Unemployed ☐
Unable to work because of disability or ill health ☐	Unable to work because of disability or ill health ☐

If there were more than 6 hospital admissions, please provide the details in the box below.

In-patient admission	**Reason for hospital in-patient admission**	**Number of nights spent in the hospital**