**We suggest obtaining the chILD-EU consent from the patient/parents, even in case the patient is not included into the register. This form covers all consents necessary for the MDT and register activities.**

**Referring Physician**

Last name: enter text

First name: enter text

Date: enter date

**Patient**

Last name: enter text

First name: enter text Gender: O Female O Male

Date of birth: enter date

**Very brief history of the patient**

**Family**

Always draw**:** family tree (separate sheet)

Consanguinity? O no O yes

Ethnicity: Mother Father

Occupation: Mother Father

Chronic diseases of relatives: ILD? O no O yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (which/who)

(mark in family tree!) other chronic diseases? O no O yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (which/who)

**Neo**

Gestational age \_\_\_\_\_ WGA if unknown: \_\_\_\_\_ term/ preterm. Birth-weight \_\_\_\_\_ g

Respiratory symptoms after births O no O yes

Need for oxygen after births O no O yes for \_\_\_\_\_ days

Need for ventilation after births O no O yes for \_\_\_\_\_ days

**Exposure**

Recurrent difficult breathing/wheezing O no O yes

Family members with Asthma diagnosis O no O yes

Atopic allergies O no O yes

Worsening of symptoms after exercise O no O yes

Pets in household O no O yes

which\_\_\_\_\_\_\_\_\_\_\_\_

Mould in household O no O yes

Birds/ feather exposure O no O yes

Recurrent otitis O no O yes

Recurrent pneumonia O no O yes

Number of pulmonary exacerbations:\_\_\_ How many with hospitalisation?\_\_\_

**Co-morbidities**

1 Failure to thrive

2 Autoimmune

3 Immuno-deficiency

4 Heart, vascular

5 Gut, pancreas

6 Hepatic, gall bladder

7 Kidney, urogenital

8 Lymphatics

9 Musculo-skeletal

10 Neurological

11 Skin, hair, nails

12 Thyroid, endocrine

13 face, syndromal features, head, neck

14 Other

**Own history**

Start chronic lung disease \_\_\_/\_\_\_ (mm/jjjj) or at age of \_\_\_\_\_\_

O insidious O suddenly O suddenly after infection O unknown

Cough O no O yes

Dyspnoea (retractions, flaring) O no O yes

Tachypnea (rate noted in box?) O no O yes

Redu. exercise tolerance O no O yes

Wheezing O no O yes

Recurrent aspirations O no O yes

Gastroesophageal reflux O no O yes

Hemoptysis O no O yes

Fan 5 point severity scale (by doctor)

O Asymptomatic

O Symptomatic, normal room air oxygen saturation under all conditions

O Symptomatic, normal resting room air saturation, but bnormal saturation (< 90%) with sleep or exercise

O Symptomatic, abnormal resting room air saturation

O Symptomatic with pulmonary hypertension

Vaccinations SARS-COV2 O nein O ja

Influenza O nein O ja RSV O nein O ja

Hib O nein O ja Pneumokokken O nein O ja

**Measurements**

Weight \_\_\_\_\_ kg

Length \_\_\_\_\_ cm

Respiratory rate \_\_\_\_\_/min

Heart rate \_\_\_\_\_/min

**O2 saturation \_\_\_\_\_/%**

Need for O2 O no O yes \_\_\_ l/min

5 min without O2 Saturation \_\_\_\_\_ %

Crackles? O no O yesa

**Investigations**

Normal? Comments

Chest CT  Type text

PFT  Type text

Cardiac US PAH: yes  no  Type text

Abnormal general lab tests Type text

Thyroid test  Type text

Immunologic tests  Type text

Auto-antibodies  Type text

IFN signature  Type text

BAL Type text

Bacteriology/virology  Type text

Genetic analyses Type, which Lab: Type text Type text

Lung biopsy Type, which Pathology: Type text

Other(s): Type text

**Current treatments**

Comments

Oxygen therapy Type text

Ventilation Type text

Enteral nutrition Type text

Corticosteroid therapy  Oral Type text

Pulses Type text

Azithromycin Type text

Hydroxychloroquin Type text

Biological(s) Type text

Other(s) Type text

**MDT Conclusion**

Clinicial’s request:  Diagnostic  Therapeutic  Other: Type text

Specify: Type text

Date:

ILD diagnosis: Type text

Proposed explorations: Type text

Management: Type text