**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