

KAWASAKI SYNDROME CASE REPORT

Patient name—last		first	middle initial	Date of birth	Age	Sex
Address—number, street		City	State	County	ZIP code	
Telephone number						
Home ()			Parent's work ()			

RACE (check one)				ETHNICITY (check one)		
<input type="checkbox"/> African-American/Black	<input type="checkbox"/> White	<input type="checkbox"/> Native American	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other _____	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Non-Latino
If Asian/Pacific Islander, please check one:				<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Chinese
				<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian
				<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian
				<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other _____

PRESENT ILLNESS

Onset date (mm/dd/yy)	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Attending physician or consultant physician	Medical record number	Telephone number ()
Admit date (mm/dd/yy)	Discharge date (mm/dd/yy)	Hospital name		Telephone number ()

Any relative with history of Kawasaki? Yes No If yes, who? _____ when? _____

Date of last carpet cleaning in residence before onset, if known (mm/dd/yy): / /

OUTCOME OF ILLNESS

Alive, no known sequelae Dead Alive with sequelae (specify): _____ Unknown

Does the patient have recurrent Kawasaki Syndrome? Yes No Unknown

If yes, list onset date of prior Kawasaki Syndrome episode (mm/dd/yy): / /

DIAGNOSTIC CRITERIA

The criteria for a case are:

- fever ≥ 5 days unresponsive to antibiotics, and at least four of the five following physical findings with no other more reasonable explanation for the observed clinical findings:
 - bilateral conjunctival injection;
 - oral changes;
 - peripheral extremity changes;
 - rash; **and**
 - cervical lymphadenopathy (at least one lymph node ≥ 1.5 cm in diameter).

Note: If the fever disappears due to intravenous gamma globulin (IVGG) therapy before the fifth day of illness, a fever of < 5 days duration fulfills fever criterion for case definition.

Did the patient have (please check):

- | | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| 1. Fever ≥ 5 days | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Number of days febrile: _____ | | | |
| 2. Bilateral conjunctival injection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 3. Oral mucosal changes (erythema of lips or oropharynx, strawberry tongue, or drying or fissuring of the lips) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 4. Peripheral extremity changes (edema, erythema, or generalized or periungual desquamation)..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 5. Rash..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| 6. Cervical lymphadenopathy > 1.5 cm diameter | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

TREATMENT

Was INTRAVENOUS GAMMA GLOBULIN given? Yes No Unknown

If yes, was it started before the fifth day of illness, while the patient was still febrile? Yes No Unknown

CARDIAC STUDIES AND RESULT

Check the results for each study type (1–3), and list the number of weeks after illness onset that the study was done. If multiple studies of any type were done, report the results of the most abnormal.

<p>1. EKG:</p> <p><input type="checkbox"/> Not done</p> <p><input type="checkbox"/> Normal results</p> <p><input type="checkbox"/> Aneurysms</p> <p><input type="checkbox"/> Other abnormalities: _____</p> <p><input type="checkbox"/> Unknown results</p> <p><input type="checkbox"/> Number of weeks after illness onset: _____</p>	<p>2. ECHO:</p> <p><input type="checkbox"/> Not done</p> <p><input type="checkbox"/> Normal results</p> <p><input type="checkbox"/> Aneurysms</p> <p><input type="checkbox"/> Other abnormalities: _____</p> <p><input type="checkbox"/> Unknown results</p> <p><input type="checkbox"/> Number of weeks after illness onset: _____</p>	<p>3. ANGIOGRAM:</p> <p><input type="checkbox"/> Not done</p> <p><input type="checkbox"/> Normal results</p> <p><input type="checkbox"/> Aneurysms</p> <p><input type="checkbox"/> Other abnormalities: _____</p> <p><input type="checkbox"/> Unknown results</p> <p><input type="checkbox"/> Number of weeks after illness onset: _____</p>
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COMPLICATIONS

Check or list any complications associated with this illness.

<p>CARDIAC:</p> <p><input type="checkbox"/> Aneurysms (coronary artery)</p> <p><input type="checkbox"/> Aneurysms (other), specify: _____</p> <p><input type="checkbox"/> Aortic regurgitation</p> <p><input type="checkbox"/> Arrhythmias</p> <p><input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> Coronary artery dilatation</p> <p><input type="checkbox"/> Mitral regurgitation</p> <p><input type="checkbox"/> Myocardial infarction</p> <p><input type="checkbox"/> Myocardial ischemia</p> <p><input type="checkbox"/> Myocarditis</p> <p><input type="checkbox"/> Pericarditis or pericardial effusion</p>	<p>NONCARDIAC:</p> <p><input type="checkbox"/> Arthralgia</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Aseptic meningitis</p> <p><input type="checkbox"/> Gall bladder hydrops</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Hepatitis or hepatomegaly</p> <p><input type="checkbox"/> Iritis or uveitis</p> <p><input type="checkbox"/> Meatitis or sterile pyuria</p> <p><input type="checkbox"/> Myalgia or myositis</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>_____</p>
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REMARKS:

Investigator name (print)	Date	Telephone number ()
Agency name		