RSV Nirsevimab Data Collection Form

Section 1: Infant's Details

Complete this part for the infant being offered Nirsevimab (PLEASE USE BLOCK CAPITALS)

Infant's First Name: _____ Infant's Surname (Family Name): _____

Infant's MRN/HCRN: _____ Infant Gender: ☐ Female ☐ Male ☐ Indeterminate

Infant's Date of birth: DD / MM / YY Time of birth: _____

Infant's gestational age at birth (Weeks): _____ Infant's birthweight (Kg): _____

Admission to neonatal unit? ☐ Y ☐ N ☐ Not known *(If no or unknown skip to section 2)*

Date of admission to neonatal unit: DD / MM / YY Date of discharge: DD / MM / YY

Principal reason for admission to neonatal unit: _____

Section 2: Mother's Details

Mother's First Name: _____

Mother's Surname: _____

Mother's MRN/HCRN: _____

Mother's Date of birth: DD / MM / YY

Mother's Eircode: _____

Please stick addressograph here or record the following details:

Mother's Address:

Maternal parity: ☐ Primparous ☐ Multiparous

Mother's Ethnic or Cultural Background:

A. White

A.1 ☐ Irish
A.2 ☐ Irish Traveller
A.3 ☐ Roma
A.4 ☐ Any other White background

B. Black

B.1 ☐ Irish
B.2 ☐ African
B.3 ☐ Any other Black background

C. Asian

C.1 ☐ Irish
C.2 ☐ Chinese
C.3 ☐ Indian
C.4 ☐ Pakistani / Bangladeshi
C.5 ☐ Any other Asian background

D. Other

D.1 ☐ Arab
D.2 ☐ Mixed origin
D.3 ☐ Other ethnic

E. Patient declined to provide information about ethnic group

E.1 ☐ Patient declined to provide information about ethnic group

Section 3: Administration Details

Parent Leaflet and Patient Information Leaflet issued: ☐ Y ☐ N

Verbal Consent: ☐ Given ☐ Declined Was Nirsevimab administered to the infant? ☐ Y ☐ N

Date of administration	Time of administration	Dose given	Batch number	Expiry date	Injection site
		☐ 50mg ☐ 100mg			☐ Rt thigh ☐ Lt thigh

Administered by [Print Name]: _____ PIN/MCRN: _____

Signature: _____

Checked by [Print Name]: _____ PIN/MCRN: _____

Signature: _____