H

FORM H — Ventriculoperitoneal shunt module

Only if B 19 = insertion of a primary ventriculoperitoneal shunt, or revision of a ventriculoperitoneal shunt

Patient identifier _____
Initials _____ Centre _____

H1	**Hydrocephalus aetiology** *(tick one)* ☐ Malformations (e.g., Spina bifida, Chiari) ☐ Aqueduct stenosis ☐ Post-haemorrhagic (e.g., SAH in adults, neonatal IVH) ☐ Tumour – benign ☐ Tumour – malignant ☐ Trauma ☐ Infection ☐ Cyst (e.g., colloid, arachnoid, pineal) ☐ Idiopathic intracranial hypertension (IIH) ☐ Idiopathic Normal Pressure Hydrocephalus (iNPH) ☐ Other, please specify
H2	**Birth status (up to 18 years old)** *(tick one)* ☐ Pre-term ☐ Term ☐ Not known
H3	**Does this patient have a concurrent CNS infection or within the last 3 months?** *(tick one)* ☐ No ☐ Yes
H4	**Is this a primary shunt insertion?** *(tick one)* ☐ No ☐ Yes
H5	**Only if:** *H4 = not a primary shunt insertion* **Revision shunt insertion — which components were revised?** *(tick one)* ☐ Ventricular catheter ☐ Peritoneal catheter ☐ Both ☐ Neither (just valve)
H6	**What shunt catheters are available in your hospital?** *(tick one)* ☐ Antibiotic only ☐ Plain only ☐ Both antibiotic and plain
H7	**Catheters used for shunt surgery** *(tick one)* ☐ Antibiotic ☐ Plain
H8	**Shunt infection (30-days)** *(tick one)* ☐ No ☐ Yes
H9	**Postoperative day shunt infection confirmed** _____ *(Date of operation is day 0)*
H10	**Shunt infection within 12 months** *(tick one)* *are you happy to be contacted at 12 months to assess for 12-month shunt infection?* *(By ticking yes, you agree to ensure you have the appropriate regulatory approvals in place and keep the data secure at your hospital (including operation date) and the team running this study module will be in touch closer to the time to assess for 12-month shunt infection)* ☐ No, please do not contact me ☐ Yes, I am happy to be contacted and acknowledge the guidance provided