



1. CHILD CURRENTLY HOT OR RECEIVED ANTIPYRETICS FOR FEVER IN THE LAST 8 HOURS?
2. AGED BETWEEN 6 MONTHS AND LESS THAN 6 YEARS?

IF YOU CAN ANSWER **YES** TO THESE TWO QUESTIONS, THEN COMPLETE THE **PITCH** PAPERWORK AND

**FAX TO (0117) 954 6647  
ANYTIME**

PLEASE ADVISE PARENTS THAT:

- THE **PITCH RESEARCH NURSE WILL CONTACT THEM BY TELEPHONE WITHIN 24 HOURS.**
- UNTIL THEN, **ANTIPYRETIC TREATMENT SHOULD CONTINUE AS PER YOUR ADVICE.**
- CONCERNS REGARDING THE CHILD'S MEDICAL CONDITION SHOULD BE DIRECTED TO NHS DIRECT OR THE CHILD'S GP.

THANK YOU

# PITCH trial prescription

Trial number: ISRCTN 26362730

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_/\_\_\_\_/20\_\_

## I confirm that

Please initial the box

### 1. This child meets the eligibility criteria:

- Is aged between 6 months and less than 6 years
- Has a fever now **OR** has been given ibuprofen or paracetamol for fever in the previous eight hours
- Does not require hospital admission for diagnosis or treatment of the underlying cause for the fever at the present time

### 2. The child:

- Has no known exclusion criteria  
(exclusions are (i) dehydration, (ii) requires hospital admission or (iii) known to have epilepsy (or other chronic neurological disease), pulmonary disease (except for asthma, this is NOT an exclusion), liver, renal or cardiac disease, previous peptic ulceration or bleeding, an allergy or intolerance to paracetamol or ibuprofen ).
- Has no known contraindication to treatment with paracetamol and/or ibuprofen
- Is not taking any regular medication that might adversely interact with paracetamol or ibuprofen (see Appendix 1, BNF for details).

- If child is NOT eligible for the study please give reason \_\_\_\_\_

Please sign below to confirm that, if the parent consents to randomisation, you are happy for the following medicines to be given to the above patient by the PITCH study team

Medicine	Dose	Quantity to be given
Paracetamol 120mg/5ml SF suspension (or placebo)	<b>DAY 1:</b> Please give 15mg/kg every 4 to 6 hours REGULARLY maximum of 4 doses in 24 hours. <b>DAY 2:</b> Please give 15mg/kg every 4 to 6 hours AS NEEDED maximum of 4 doses in 24 hours.	140ml
<b>AND</b>		
Ibuprofen 100mg/5ml SF suspension (or placebo)	<b>DAY 1:</b> Please give 10mg/kg every 6 to 8 hours REGULARLY maximum of 3 doses in 24 hours. <b>DAY 2:</b> Please give 10mg/kg every 6 to 8 hours AS NEEDED maximum of 3 doses in 24 hours.	100ml

...../...../20.....

Name of Doctor  
(BLOCK CAPITALS or PRACTICE STAMP)

Date

Signature

**PLEASE TURN OVER AND COMPLETE THE CLINICAL DETAILS**

# QUESTIONS ABOUT THE CHILD'S FEVER AND TREATMENT.

**1. If measured (parent or clinician), please record the child's most recent temperature (°C) and time:**

**NB.** A measured temperature is NOT a requirement for referral to the PITCH team

Temp (°C)

 :  :  : 

Time (24 hour clock)

**2. Please explain how this was assessed (tick one box only)**

By touch (e.g. hand on forehead) . . .  <sup>1</sup>

Electronic axillary thermometer . . .  <sup>2</sup>

Tympanic thermometer . . .  <sup>3</sup>

Other . . .  <sup>4</sup>

If other please explain: \_\_\_\_\_

**3. How would you classify the cause of this child's fever?**

Upper respiratory tract infection . . .  <sup>1</sup>

Lower respiratory tract infection  <sup>2</sup>

Otitis media . . .  <sup>3</sup>

Tonsillitis . . .  <sup>4</sup>

Infective exacerbation of asthma . . .  <sup>5</sup>

Pneumonia (clinical diagnosis) . . .  <sup>6</sup>

Gastroenteritis . . .  <sup>7</sup>

Non-specific viral illness . . .  <sup>8</sup>

Other  <sup>9</sup>

If other please specify: \_\_\_\_\_

**4. How would you rate the severity of the underlying illness?**

Minor . . .  <sup>1</sup> (E.g. no follow up arrangements in place)

Intermediate . . .  <sup>2</sup> (E.g. asked to come back if not improving)

Moderate . . .  <sup>3</sup> (E.g. Does not require admission, but specific follow up arrangement in place)

**5. Have you prescribed an antibiotic**

Yes

No

**6. Please list the names (only) of all new medication (e.g. antibiotics, inhalers) you have advised or prescribed:**

\_\_\_\_\_

\_\_\_\_\_

**7. Is the child receiving regular medication?**

Yes

No

**8. Please list the names (only) of all medication the child usually receives:**

\_\_\_\_\_

\_\_\_\_\_

**9. Please indicate which antipyretic medicines you would ordinarily have advised this child to use:**

P = paracetamol, I = ibuprofen only, P+I = both

P

I

P+I

Thank you. Please ask the parent to sign the form on the next page and then ask your secretary to fax the **WHOLE FORM** to the **PITCH** research team as soon as possible to **(0117) 954 6647**.

I agree that details of my child's current episode of illness, treatment and my contact details given below can be given (in person or by telephone or secure fax) to the researchers carrying out the **PITCH** trial. This will enable them to contact me and explain the trial in more detail so that I can then decide whether or not to take part.

(BLOCK CAPITALS PLEASE)

Child's name:

.....

Parent/Guardian's

Name:

.....

Mr/Mrs/Miss/Ms

Forename

Surname

Address:

.....

.....

.....

Postcode:

.....

Main contact  
number:

.....

Alternative contact  
number:

.....

.....

Signature of parent/guardian

...../...../20.....

Date