Paediatric Assessment Form

Mother/Carer’s name: ................................................................. Box/Pack number:..............................................

Child’s name: ................................................................. Date of birth:..............................................

1. Does the child have any congenital malformation? Yes ❑ No ❑
   If yes, describe ........................................................................................................................................

2. How disabled is the child? mild-moderate ❑ severe ❑ not disabled ❑

   Does the child have any difficulty with head control? Yes ❑ No ❑
   If yes, unstable but no support needed
   unable to control head without support

   Does the child have any difficulty with sitting? Yes ❑ No ❑
   If yes, sits unsupported but unstable
   sits only if supported
   unable to sit

   If the child is less than 12 months go to Q6

3. Does the child have any difficulty with walking? Yes ❑ No ❑
   If yes, non-fluent gait
   abnormal gait, reduced mobility
   unable to walk without assistance

4. Does the child have any difficulty with hand use? Yes ❑ No ❑
   If yes, some difficulty feeding, one hand
   some difficulty feeding, both hands
   unable to feed self

5. Does the child have seizures? Yes ❑ No ❑
   If yes, no treatment required
   no seizures on treatment
   <1 seizure/month on treatment
   >1 seizure/month on treatment

6. Does the child have any visual difficulty? Yes ❑ No ❑
   If yes, normal vision with correction
   not fully correctable defect
   blind or visual acuity of <6/60
   Results of optometry, if known

   visual acuity

For office use

…………………………………..........……………………………………………………………
8. **Does the child have a hearing difficulty?**

   - No
   - Yes

   **If yes,** hearing impaired but not aided
   - hearing impaired and has a hearing aid
   - **Degree of hearing loss (dB), if known**

9. **Does the child have difficulty with communication?**

   - No
   - Yes

   **If yes and child aged 18-36 months:**
   - unable to comprehend word/sign out of familiar context
   - unable to comprehend word/sign in cued situation
   - uses single words only and vocabulary >10 words
   - vocabulary <10 words
   - unable to produce >5 recognisable sounds
   - no vocalisation

   **If yes and child aged <2 years, describe level of vocalisation and understanding of language**

10. **Does the child have gastrointestinal or feeding problems?**

    - No
    - Yes

    **If yes,** special diet
    - stoma
    - tube feeding
    - parenteral nutrition
    - other, describe

11. **Does the child have respiratory problems?**

    - No
    - Yes

    **If yes,** limited exercise tolerance, no drugs
    - limited exercise tolerance on drugs
    - oxygen therapy >1 hour/day
    - mechanical ventilation or tracheostomy

12. **Does the child have renal impairment?**

    - No
    - Yes

    **If yes,**
    - no treatment
    - treated with drugs or diet
    - treated with dialysis

13. **Do you think the child has cerebral palsy?**

    - No
    - Yes

    **If yes,** describe

    How disabled is the child?
    - mild
    - moderate
    - severe

14. **Does the child have any other disability?**

    - No
    - Yes

    **If yes,** describe
15 Have you done a Bayley assessment? Yes ☐ No ☐
If yes, what was the Psychomotor Index Score? ☐ ☐ ☐ ☐
what was the Mental Developmental Index Score? ☐ ☐ ☐ ☐

16 Or, have you done a Griffith assessment Yes ☐ No ☐
If yes, what was the total quotient? ☐ ☐ ☐ ☐
and what was the score for? locomotor ☐ ☐ ☐ ☐
personal social ☐ ☐ ☐ ☐
hearing and speech ☐ ☐ ☐ ☐
hand and eye ☐ ☐ ☐ ☐
performance ☐ ☐ ☐ ☐

17 Or, have you done any other neurodevelopmental assessment? Yes ☐ No ☐
If yes, which one? .................................................................
what was the score? ..............................................................
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Ask the mother, is there anything else you would like to tell me about your child?
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Name of person completing this form: .................................................................

Date child assessed: ..................................................................

Are you a:  Paediatrician ☐ Other doctor ☐ Nurse ☐ Midwife ☐
Other ☐ specify .................................................................