

# TRPG/SEND TWO-YEAR CORRECTED AGE OUTCOME FORM

PLEASE DO NOT COMPLETE THIS FORM IF THE CHILD IS ACUTELY ILL

Name & Designation of person completing form \_\_\_\_\_

Hospital of Birth \_\_\_\_\_

Infant's name \_\_\_\_\_ Infant's NHS No \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of assessment \_\_\_\_/\_\_\_\_/\_\_\_\_

Gestation at birth (completed weeks) \_\_\_\_\_ Sex: Male / Female

Reason if child not assessed: Deceased post discharge / lost to follow up

Full *Current* Post Code \_\_\_\_\_ Date of death if applicable \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth weight \_\_\_\_\_ Current hospital of follow up: \_\_\_\_\_

1. Neuromotor:	No	Yes	Don't Know
a. Does this child have any difficulty walking?			
b. Is this child's gait non-fluent or abnormal reducing mobility?			
<b>c. Is this child unable to walk without assistance?</b>			
d. Is this child unstable or needs to be supported when sitting?			
<b>e. Is this child unable to sit?</b>			
f. Does this child have any difficulty with the use of one hand?			
g. Does this child have difficulty with the use of both hands?			
<b>h. Is this child unable to use hands (i.e. to feed)?</b>			
2. Malformations:			
a. Does this child have a malformation identified at birth/ within the first 2yrs?			
<b>b. Does this malformation impair daily activities despite assistance?</b>			
3. Respiratory & CVS system:			
a. Does this child have limited exercise tolerance with or without treatment?			
<b>b. Does child require supplemental oxygen or other respiratory support</b>			
4. Gastro-intestinal Tract:			
a. Is this child on a special diet? If yes, what diet: _____			
b. Does this child have a stoma?			
<b>c. Does this child require TPN, NG or PEG feeding?</b>			
5. Renal:			
a. Does this child have renal impairment, no treatment?			
b. Is this child on dietary or drug treatment for renal impairment?			
<b>c. Is this child having renal dialysis or awaiting renal transplant?</b>			

6. Neurology:	No	Yes	Don't know
a. Has this child had a fit or seizure in the past 12 months?			
b. Is this child on any anticonvulsants?			
<b>c. Has this child had more than 1 seizure a month despite treatment?</b>			
d. Has this child ever had ventriculo-peritoneal shunt inserted?			
7. Growth: Give date of measurements if different from date of assessment _____			
Weight _____ kg Date _____			
Length _____ cm Date _____			
Head circumference _____ cm Date _____			
8. Development	No	Yes	Don't Know
a. Is the child's development between 3-6 months behind corrected age?			
b. Is the child's development between 6-12 months behind corrected age?			
<b>c. Is the child's development more than 12 months behind corrected age?</b>			
d. Will you be referring the child for a detailed neurodevelopmental assessment?			
e. If child had detailed neurodevelopmental assessment, please provide name of the test.			
9. Neurosensory:			
a. Does this child have a hearing impairment?			
b. Does this child have hearing impairment corrected by aids?			
<b>c. Does this child have hearing impairment not correctable with aids?</b>			
d. Does this child have any visual problems (including squint)?			
e. Does this child have visual defect that is not fully correctable?			
<b>f. Is this child blind or sees light only?</b>			
10. Communication			
a. Does this child have any difficulty with communication?			
b. Does this child have difficulty with speech (<10 words/signs)?			
<b>c. Does the child have &lt;5 meaningful words, vocalisations or signs?</b>			
d. Does this child have difficulty with understanding outside of familiar context?			
<b>e. Is this child unable to understand words or signs?</b>			
Special Questions:			
a. Is this child on at-risk register, fostered or adopted?			
b. Was this child difficult to test? If yes, circle appropriate below: (a) tired, (b) poor attention, (c) difficult to engage, (d) other			

Note: If answering 'yes' to questions 1a - 1h or question 2b, please classify on the reverse of this form

1) Does this child have Cerebral Palsy?

Yes	No
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If yes, please classify:

Spastic bilateral: 2 limb involvement	
Spastic bilateral: 3 limb involvement	
Spastic bilateral: 4 limb involvement	
Hemiplegia: Right sided	
Hemiplegia: left sided	
Dyskinetic/ dystonic/ choreo-athetoid	
Not classifiable	

2) Please give diagnosis: \_\_\_\_\_