Please return completed form to: BOOSTII Coordinating Centre, Locked Bag 77, Camperdown NSW 1450.
Ph: 61 2 9562 5000, Fax: +61 2 9565 1863, Email: boost2@ctc.usyd.edu.au

Health Status at Two Years – Paediatrician's Form

Site number	6	1				Child's study number					
Child's full name	first		middle		last						
Child's Initials (xxx or x-x)				Date form completed:	day	month	year				
Child's expected date of birth	day	month	year	Corrected age when examined:	months	weeks	days				
Parent/Guardian Contact Details											
Name of Assessor											
Grade of Assessor											

Please tick the most appropriate choice in **BLUE** boxes

Child's Ability		
1. To control their head (tick one only)	controls head movement well	
	poor control but does not need support	
	can control head only with support	
2. To sit (tick one only)	sits alone for long periods	
	sits unsupported but unstable	
	sits only with support	
	unable to sit	
3. To walk (tick one only)	walks well without help	
	has an unsteady walk	
	unable to walk without help	
	cannot walk	

4. To pick up a small object (tick one only for each hand)		Left Hand	Right Hand
	Uses pincer grip		
	Picks up by other means		
	Unable to pick up object		

5. To use both hands (bimanual tasks)	Uses both hands well	
(tick one only)	Some difficulty using one hand	
	Unable to use both hands together	

6. Has this child had any seizures or convulsions		Yes	No
If yes, was it or were they: (tick all that apply)	Febrile?		
	Non-febrile?		
	Unsure?		
6a. Treatment and frequency of non-febrile seizures: (tick one only)	No treatment required		
	No seizures on treatment		
	Up to 1 seizure/month on treatment		
	More than 1 seizure/month on treatment		

Vision

7. Is this child legally blind? (vision worse than 6/60 in both eyes)					Yes	No
7a. If Yes, (tick all that apply)	Caused by Retinopathy of Prematurity (ROP)		Caused by Cortical Impairment		Other	
If Other, please describe:						
7b. Does this affect (tick only one)	Left Eye		Right Eye		Both	

8. Does this child have a squint?	Yes	No
9. Does this child wear glasses?	Yes	No

10. Usual vision (with glasses if worn) – give your clinical opinion: (tick one only)	Normal / nearly normal	
	Impaired but useful vision for everyday activities	
	Impaired but can see objects close up	
	Sees light only, or no vision	

Hearing

11. Does this child have hearing loss?		Yes	Suspected	No
11a. If Yes or suspected, is it: (tick one only)	Sensorineural?			
	Conductive?			
	Other type/mixed?			
	Unknown?			
11b. If Yes or suspected: (tick one only)	Has some hearing problems does NOT need a hearing aid			
	Hears well or with only a little difficulty WITH a hearing aid			
	Has severe hearing difficulty with a hearing aid or hearing is not helped with an aid			

Communication			
12. Does this child understand either words or signed words		Yes	No
13. Does this child use any recognisable words? (this includes signed words)		Yes	No
If yes, approximately how many?			
If no, do they use any sounds that parents understand?		Yes	No
If yes, approximately how many?			
Feeding			
14. Does this child need tube feeds or parenteral nutrition		Yes	No
If Yes does he/she have: (tick all that apply)	Nasogastric feeds?		
	Gastrostomy feeds?		
	Parenteral feeds?		
Respiratory			
15. When this child was discharged from the neonatal unit, did they need oxygen at home?		Yes	No
If Yes, is oxygen still required		Yes	No
If no longer on oxygen when was it discontinued		month	Year
16. Does this child have asthma		Yes	No
If Yes, is the child getting prophylaxis (e.g. regular steroid inhaler or Intal)		Yes	No
17. Does this have chest symptoms? (e.g. cough or wheeze)		Yes	No
If Yes, how frequent are these symptoms: (tick one only)			
	More than once a week?		
	Once a week or less but more than once a month?		
	Once a month or less?		
18. Is this child currently on any medicines for chest symptoms?		Yes	No
If Yes, which of the following does he/she need? (tick all that apply)			
	Relievers (e.g. Ventolin or Bricanyl) - *Used everyday*		
	Relievers (e.g. Ventolin or Bricanyl) – *Used only when needed*		
	Preventers (e.g. pulmicort/becotide/flixotide/intal)?		
	Steroids (e.g. prednisolone)?		
	Antibiotics		
	Other		
19. Is this child currently on any other treatments for chest symptoms? (tick all that apply)			
	Limited exercise tolerance, due to respiratory complications?		
	Mechanical ventilation?		
	Tracheostomy (current)?		
	Tracheostomy (ever)?		
	None of these		

Renal			
20. Does this child have kidney problems?		Yes	No
If Yes, how treated? (tick one only)			
	Not treated?		
	Treated with drugs or diet?		
	Treated with dialysis		
Hospital Admissions			
21. How many times has this child been admitted to hospital since discharge home from the neonatal unit?			
	Tick here if not known		
Examination			
22. Height in cm (or length for <2 years' corrected age)			.
23. Weight in kg		.	
24. Head Circumference in cm		.	

25. Does this child have abnormal unwanted movements? (do not include seizures)		Yes	No
If Yes, are they: (tick all that apply)			
	Short and jerky?		
	Slow and writhing?		
	Tremor?		
	Flexo/extensor spasms?		
	Inco-ordination? (not secondary to increased tome or weakness?		

26. Please indicate muscle tone in each limb and trunk (please tick one box of each column)	Left Arm	Right Arm	Left Leg	Right Leg	Trunk
Normal					
Increased					
Decreased					
Varying					

28. Describe reflexes (please tick one box of each column)	Biceps		Knee		Ankle	
	Left	Right	Left	Right	Left	Right
Normal						
Increased						
Decreased or absent						
Plantar reflexes - Left	Up		Down		Unobtainable	
Plantar reflexes - Right	Up		Down		Unobtainable	

Summary of Disability										
29. Do you think this child has cerebral palsy						Yes		Possibly		No
Spastic bilateral					2 limb movement					
					3 limb movement					
					4 limb movement					
Hemiplegia					Right side					
					Left side					
Dyskinetic					Dystonic					
					Choreo-athetotic					
					Ataxic					
Define the GMFCS[1]	Level 1		Level 2		Level 3		Level 4		Level 5	
If 'Possibly', please describe findings:										

30. Does this child have hydrocephalus with a shunt?	Yes	No

31. Does this child have any other neurological problems?	Yes	No
If Yes, please describe:		

Overall development		
32. In your opinion is this child's development delayed?	Yes	No
If Yes, please indicate by how much development is delayed: (tick one box only)		
Less than 4 months delayed		
4-6 months delayed		
7-9 months delayed		
10-12 months delayed		
Less than 12 months delayed		
More than 12 months delayed		

33. Are there any concerns about this child's health which might have been related to their participation in BOOSTII?	Yes	No
If Yes, please describe:		

34. Does this child have any other medical diagnoses not covered by questions 1 to 33	Yes	No
If Yes, please describe:		

35. Does this child have any other impairment or anomaly not covered by questions 1 to 34	Yes	No
If Yes, please describe:		
If Yes, is the above disability: (tick one box only)		
Mild - some limitation present but able to function independently		
Moderate - aids or assistance may be required to perform tasks		
Severe - unable to perform tasks without aids and or assistance most of the time or is completely dependent of carer to perform tasks		

What to do now:

- If you have any questions about this form or how to answer any of the questions please contact your BOOSTII coordinator:

Or the:

BOOSTII Coordinating Centre, NHMRC Clinical Trials Centre, The University of Sydney
Locked Bag 77, Camperdown 1450
Ph: 02-9562 5000; Fax: 02-9565 1863; Email: boost2@ctc.usyd.edu.au

- Please make sure all the questions of this form have been completed. Please return this form using the Reply Paid envelope provided (no stamp required), or to one of the addresses stated above.

Thank you for completing this form

1. Gross Motor Function Classification System (GMFCS), Palisano et al, Dev Med Child Neurol 1997; 39: 214-223