TRPG/SEND/NNAP 2–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?			
	c. **Is this child unable to walk without assistance**?			
	d. Is this child unstable or needs to be supported when sitting?			
	e. **Is this child unable to sit?**			
	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?			
	h. **Is this child unable to use hands (i.e. to feed)?**			
	2. **Malformations:**			
	a. Does this child have a malformation identified at birth/ within the first 2yrs?			
	b. **Does this malformation impair daily activities despite assistance?**			
	3. **Respiratory & CVS system:**			
	a. Does this child have limited exercise tolerance with or without treatment?			
	b. Does child require supplemental oxygen or other respiratory support			
	4. **Gastro-intestinal Tract:**			
	a. Is this child on a special diet? If yes, what diet:_____			
	b. Does this child have a stoma?			
	c. Does this child require TPN, NG or PEG feeding?			
	5. **Renal:**			
	a. Does this child have renal impairment, no treatment?			
	b. Is this child on dietary or drug treatment for renal impairment?			
	c. Is this child having renal dialysis or awaiting renal transplant?			

	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?			
	c. Has this child had more than 1 seizures a month despite treatment?			
	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?			
	c. Is the child's development more than 12 months behind corrected age?			
	d. Will you be referring the child for a detailed neurodevelopmental assessment?			
	e. If child had detailed neurodevelopmental assessment, 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?			
	c. Does this child have hearing impairment not correctable with aids?			
	d. Does this child have any visual problems (including squint)?			
	e. Does this child have visual defect that is not fully correctable?			
	f. **Is this child blind or sees light only?**			
	10. **Communication**			
	a. Does this child have any difficulty with communication?			
	b. Does this child have difficulty with speech (<10 words/signs)?			
	c. Does the child have <5 meaningful words, vocalisations or signs?			
	d. Does this child have difficulty with understanding outside of familiar context?			
	e. Is this child unable to understand words or signs?			
	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, 2b or 8e please classify/enter score on the reverse of this form

1) Does this child have Cerebral Palsy?	Yes	No

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: _____

Bayley III (if performed) – please enter RAW scores	
Cognitive	
Receptive language	
Expressive language	
Fine Motor	
Gross motor	
Social emotional	
Adaptive behaviour (enter sum of scaled scores)	
Notes	

Griffiths (if performed) – please enter RAW scores	
A Locomotor	
B Personal and social	
C Hearing and Language	
D Eye and hand coordination	
E Performance	
F Practical reasoning	
Notes	

Schedule of Growing Skills (if performed) – please enter RAW scores	
Locomotor	
Manipulative	
Interactive Social	
Self-care social	
Hearing and Language	
Speech and Language	
Visual	
Notes	

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