

Center: \_\_\_ Site: \_\_\_ Network No. \_\_\_ Birth No. \_\_\_ Mother's Initials: \_\_\_\_\_

- 1. Follow-up Number: \_\_\_\_\_
- 2. Birth Date: \_\_\_\_\_  

Month
Day
Year
- 3. Mother's initials (first, middle, last): \_\_\_\_\_
- 4. Gestational age: Weeks \_\_\_\_\_ Days \_\_\_\_\_
- 5. Birth Number: \_\_\_\_\_
- 6. Were Generic forms completed at a different center: Yes No
  - a. If Yes, give the previous center's Generic network number for the child: \_\_\_\_\_
  - b. If yes, give the previous Center's number: \_\_\_\_\_
  - c. If No, GDB Network number from current site: \_\_\_\_\_

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

This form should be completed for all infants eligible for the Follow-up Study at the time of discharge to home or to chronic care.

**A. DEMOGRAPHIC DATA**

1. Date of discharge: \_\_\_\_\_  
Month Day Year

*User will be prompted to verify values calculated by DMS.*

2. Date of birth: \_\_\_\_\_  
Month Day Year

3. Age  
a. Chronological age: \_\_\_\_\_ Weeks  
b. Corrected age: \_\_\_\_\_ Weeks

4. Will the child be under state supervision? Y N

5. Primary caretaker: \_\_\_\_\_  
(Parent/Legal Guardian, person who is primarily responsible for parenting the child)  
(See Relationship Codes—if biological mother, code is 001)

6. Other caretaker: \_\_\_\_\_  
(See Relationship Codes. If no other caretaker, leave data field blank)

7. Primary Caretaker's marital status: \_\_\_\_\_  
1=Married 3=Divorced  
2=Single 4=Widowed

**B. HOUSEHOLD COMPOSITION**

1. Baby's planned living arrangements: \_\_\_\_\_  
(See Living Arrangement Codes)

**IF BABY'S PLANNED LIVING ARRANGEMENTS ARE CODES 16, 17, 18 OR 19, SKIP TO C.4 OF THIS FORM.**

2. Number of people living in baby's household: \_\_\_\_\_

**C. EDUCATION AND OCCUPATION**

1. Apart from the Primary Caretaker, do others contribute money to the child's household? Y N

2. Highest grade completed or attended:  
a. Primary Caretaker \_\_\_\_\_  
b. Other Caretaker \_\_\_\_\_

1=< 7 <sup>th</sup> grade	5=Partial college
2=7 <sup>th</sup> to 9 <sup>th</sup> grade	6=College degree
3=10 <sup>th</sup> to 12 <sup>th</sup> grade	7=Graduate degree
4=High School degree	8=Unknown

3. Currently working  
a. Primary Caretaker? Y N  
b. Other Caretaker? Y N NA

4. Baby's medical insurance: \_\_\_\_\_  
1=Public 4=Uninsured  
2=Private (Employment/purchased) 5=Unknown  
3=Both Public and Private

**D. FORM COMPLETION**

1. Where was interview conducted: \_\_\_\_\_  
1=Clinic 3=Telephone 9=Other  
2=Home 4=Hospital

2. Date of SES interview: \_\_\_\_\_  
Month Day Year

3. Initials of person administering SES at Discharge: \_\_\_\_\_



Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

This form should be completed for all children examined at the Follow-up visit.

**A. DEMOGRAPHIC DATA**

1. Date of visit: \_\_\_\_\_  
Month Day Year

*User will be prompted to verify values calculated by DMS.*  
2. Date of birth: \_\_\_\_\_  
Month Day Year

3. Age  
a. Chronological age: \_\_\_\_\_ Months  
b. Corrected age: \_\_\_\_\_ Months

4. Is the child under state supervision? Y N

5. Primary caretaker: \_\_\_\_\_  
(Parent/Legal Guardian, person who is primarily responsible for parenting the child)  
(See Relationship Codes—if biological mother, code is 001)

6. Other caretaker: \_\_\_\_\_  
(See Relationship Codes. If no other caretaker, leave data field blank)

7. Primary Caretaker's marital status: \_\_\_\_\_  
1=Married 3=Divorced  
2=Single 4=Widowed

**B. HOUSEHOLD COMPOSITION**

1. Child's current living arrangements: \_\_\_\_\_  
(See Living Arrangement Codes)

**IF CHILD'S CURRENT LIVING ARRANGEMENTS ARE CODES 16, 17, 18 OR 19, SKIP TO C.4 OF THIS FORM.**

2. Number of people living in child's household: \_\_\_\_\_

**C. EDUCATION AND OCCUPATION**

1. Apart from the Primary Caretaker, do others contribute money to the child's household? Y N

2. Highest grade completed or attended:  
a. Primary Caretaker \_\_\_\_\_  
b. Other Caretaker \_\_\_\_\_

1=< 7 <sup>th</sup> grade	5=Partial college
2=7 <sup>th</sup> to 9 <sup>th</sup> grade	6=College degree
3=10 <sup>th</sup> to 12 <sup>th</sup> grade	7=Graduate degree
4=High School degree	8=Unknown

3. Currently working  
a. Primary Caretaker? Y N  
b. Other Caretaker? Y N NA

4. Child's medical insurance: \_\_\_\_\_  
1=Public 4=Uninsured  
2=Private (Employment/purchased) 5=Unknown  
3=Both Public and Private

**D. HOUSEHOLD INFORMATION**

1. Primary Language spoken to the child over the last year: \_\_\_\_\_  
1=English 2=Spanish 3=Other

a. If Other, specify \_\_\_\_\_

2. Was a second language spoken to the child over the last year: Y N

a. If YES, secondary language \_\_\_\_\_  
1=English 2=Spanish 3=Other

i. If Other, specify \_\_\_\_\_

3. Number of places the child has lived since discharge \_\_\_\_\_

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**E. SPECIAL CHILD SERVICES**

1. Is the child receiving or has (s)he received any of the following services:  
 1=No      2=Received but discontinued      3=Receiving  
 4=Recommended but not receiving

1) Received?

- a. Visiting nurse \_\_\_\_\_
  - b. Home nurse \_\_\_\_\_
  - c. OT/PT \_\_\_\_\_
  - d. Speech Therapy \_\_\_\_\_
  - e. Early Intervention program (infant stimulation) \_\_\_\_\_
  - f. Social worker for the child \_\_\_\_\_
  - g. Specialty medical/surgical clinical visit \_\_\_\_\_
    - 1. Pulmonary \_\_\_\_\_
    - 2. Ophthalmologic \_\_\_\_\_
    - 3. Gastrointestinal \_\_\_\_\_
    - 4. Audiologic \_\_\_\_\_
    - 5. Neurologic \_\_\_\_\_
    - 6. ENT \_\_\_\_\_
    - 7. Cardiology \_\_\_\_\_
    - 8. Urology \_\_\_\_\_
    - 9. Neurosurgery \_\_\_\_\_
    - 10. General surgery \_\_\_\_\_
    - 11. Other, \_\_\_\_\_
    - 11a. Specify \_\_\_\_\_
  - h. Neurodevelopmental/Behavioral clinical visit \_\_\_\_\_
  - i. NICU Follow Up Clinic \_\_\_\_\_
2. Does the child have a regular doctor or clinic where you take him/her for routine health care?      Y      N

**F. DAY CARE/CHILD CARE in the past month (Check all that apply.)**

1. Does this child reside in a chronic care facility?      Y      N  
**If YES, skip to section G. If NO continued to question 2.**
2. Is your child taken care of by someone other than the primary caregiver (If YES, answer all that apply.)      Y      N
- a. Traditional center-based day/child care      Y      N
    - i. If YES, average hours per week      \_\_\_ Hrs. per week
  - b. Medical (specialized) child care by medical professionals      Y      N
    - i. If YES, average hours per week      \_\_\_ Hrs. per week
    - ii. If YES, record where \_\_\_\_\_  

1=Primary Caregivers home	2=Relative's home	3=Other Home	4-Facility
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  - c. Traditional Home-based day/child care      Y      N
    - i. If YES, average hours per week      \_\_\_ Hrs. per week
    - ii. If YES, record whose home \_\_\_\_\_  

1=Primary Caregivers home	2=Relative's home	3=Other Home
---------------------------	-------------------	--------------
  - d. Babysitter/Au Pair      Y      N
    - i. If YES, average hours per week      \_\_\_ Hrs. per week
    - ii. If YES, relation to child \_\_\_\_\_  

1=Relative	2=Non-relative
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Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

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**G. FORM COMPLETION**

1. Primary responder \_\_\_\_\_  
(Use codes listed on the right side of this page or Appendix B of manual.)
2. Where was interview conducted: \_\_\_\_\_
- |          |             |         |
|----------|-------------|---------|
| 1=Clinic | 3=Telephone | 9=Other |
| 2=Home   | 4=Hospital  |         |
3. Date of SES interview: \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year
4. Initials of person administering SES at Follow-up: \_\_\_\_\_

**Relationship Codes (used for Question G.1)**

001 - Mother of Child  
 002 - Father of Child  
 011 - Husband, Significant Other (SO)(if different from 002)  
 012 - Wife, Girlfriend (if different from 001)  
 021 - Maternal grandmother  
 022 - Paternal (SO) grandmother  
 031 - Maternal grandfather  
 032 - Paternal (SO) grandfather  
 041 - Maternal aunt  
 042 - Paternal (SO) aunt  
 051 - Maternal uncle  
 052 - Paternal (SO) uncle  
 061 - Brother  
 062 - Step Brother  
 071 - Sister  
 072 - Step Sister  
 081 - Maternal female cousin  
 082 - Paternal (SO) female cousin  
 091 - Maternal male cousin  
 092 - Paternal (SO) male cousin  
 101 - Other maternal relative  
 102 - Other paternal (SO) relative  
 201 - Foster mother  
 202 - Foster father  
 301 - Adoptive mother  
 302 - Adoptive father  
 401 - Other non-relative  
 402 - Social worker/case worker  
 501 - Staff in congregate care  
 502 - Still hospitalized  
 504 - Unknown

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**This form should be completed for all children who are examined at the Follow-up visit.****A. MEDICAL HISTORY**

1. Has the child been rehospitalized since discharge to home or chronic care facility? Y N

**IF YES, COMPLETE THE NF04A FORM**

- a. If Yes, How many times has the child been rehospitalized? \_\_\_ \_\_\_
2. Has your child taken any of the following medications repeatedly in the last 3 months? Y N

If YES, use following to code answers

1=No	2=Yes, but stopped	3=Yes, still using
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- a. Anti-reflux medications? \_\_\_
- b. Asthma/BPD medications? \_\_\_
- c. Anticonvulsants/Seizure medications? \_\_\_
- d. Thyroid medications? \_\_\_
- e. Muscle relaxants and/or antispasticity medications? \_\_\_
3. Has the child had one or more seizures since discharge? Y N
4. Has the child been diagnosed with (or suspected to have) Autism Spectrum Disorders? Y N
5. Is the child currently using any of the following:
- a. Apnea monitor Y N
- b. Oxygen Y N
- c. Ventilator/CPAP Y N
- d. Gastrostomy tube and/or tube feeding Y N
- e. Tracheostomy Y N
- f. Pulse Oximeter Y N

6. Oral Motor Skills (*choose one*) \_\_\_\_\_
- 1=Independently feeds self most foods/liquids by mouth
- 2=Dependent oral feeding: all p.o., but requires more than occasional assistance
- 3=Limited oral feeding (requires some food via alternate route; *specify below*)
- 4=No oral feeding

**If 3 or 4 for Q6 Oral Motor Skills answer Y or N to 6a and 6b:**

- 6a. Tube (NG/ND, G-tube/button, other enteral) Y N
- 6b. TPN Y N
7. Feeding behaviors/behavioral difficulties (*answer Yes or No to each*)
- a. Resists/refuses some/all food by mouth (due to oral aversion) Y N
- b. Difficulty with swallowing food (at mouth or throat level due to dysphagia) Y N
- c. Documented aspiration (food down windpipe) Y N
8. High calorie oral supplements Y N
9. Oral diet texture (*answer a-d below; more than one YES may be applicable*)
- a. Thin liquids Y N
- b. Thickened liquids Y N
- c. Soft solids (baby food, pureed food) Y N
- d. Table food (requiring chewing) Y N
10. Does your child use any of the following equipment or has any been ordered? If YES,
- a. Adapted stroller/wheelchair? Y N
- b. Braces/orthotics? Y N
- c. Walker? Y N
- d. Stander? Y N
- e. Corner chairs or tumbler form? Y N

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

11. Has the child had any operations since discharge to home or chronic care

facility? Y N

If YES, has the child had:

a. Tympanostomy tubes placed? Y N

b. Tracheostomy? Y N

c. Eye surgery? Y N

c1. If Yes, indicate reason(s): \_\_\_\_\_

1=strabismus 2=cataract 3=ROP 4=other (specify)\_\_\_\_\_

d. Hernia surgery? Y N

e. Gastrostomy tube placed? Y N

f. Fundoplication? Y N

g. Shunt for hydrocephalus? Y N

h. Reanastomosis of large or small intestine? Y N

i. Stricture repair/lysis of adhesions? Y N

j. Bowel lengthening surgery? Y N

j1.Specify type (i.e., STEP, Bianchi)\_\_\_\_\_

k. Other bowel surgery? (specify)\_\_\_\_\_ Y N

l. Bronchoscopy? Y N

m. Other? (specify)\_\_\_\_\_ Y N

**B. FORM COMPLETION**

1. Where was interview conducted: \_\_\_\_\_

1=Clinic	3=Telephone	9=Other_____
2=Home	4=Hospital	

2. Date when Medical History obtained: \_\_\_\_\_  
Month Day Year

3. Initials of person administering Medical History Form: \_\_\_\_\_



Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

If the child has been rehospitalized (readmissions to any hospital since discharge to home or chronic care that required at least one overnight stay) complete the following:

**A. HOSPITALIZATIONS**

1. Date of discharge to home or chronic care: \_\_\_\_\_  
Month Day Year

2. Date of first birthday: \_\_\_\_\_  
Month Day Year

3. Readmission	4. Time Period: (see codes below)	5. Primary Cause: (see codes below)	6. Length of hospital stay (see codes below)	7. Did child spend any time in the ICU? (Circle Yes, No, or Don't Know)
01	___	___	___	Y N DK
02	___	___	___	Y N DK
03	___	___	___	Y N DK
04	___	___	___	Y N DK
05	___	___	___	Y N DK
06	___	___	___	Y N DK
07	___	___	___	Y N DK
08	___	___	___	Y N DK
09	___	___	___	Y N DK

**TIME PERIOD CODES**

- 1 = Prior to or on 1st birthday
- 2 = After 1st birthday

- 1 = Respiratory
- 2 = CNS
- 3 = Surgery
- 4 = Infection

**PRIMARY CAUSE CODES**

- 5 = Growth and Nutrition
- 6 = Environmental
- 7 = Other; specify: \_\_\_\_\_

- 8 = Apnea/Apparent life threatening event
- 9 = Reflux
- 11 = Trauma (Accidental)
- 12 = Trauma (Non accidental)
- 13 = Vomiting/diarrhea/dehydration
- 14 = Sleep study

**LENGTH OF STAY CODES**

- 1 = 1 week or less
- 2 = More than 1 week

**B. FORM COMPLETION**

1. Where was interview conducted: \_\_\_\_\_  
1 = Clinic 3 = Telephone 9 = Other  
2 = Home 4 = Hospital

2. Date Readmission information obtained: \_\_\_\_\_  
Month Day Year

3. Initials of person administering Readmission form: \_\_\_\_\_

This form should be completed for all children examined at the Follow-up visit.

**A. PHYSICAL EXAMINATION**

- 1. Weight: \_\_\_\_\_ kg
- 2. Recumbent length: \_\_\_\_\_ cm
- 3. Occipital-frontal circumference: \_\_\_\_\_ cm

**B. NEUROLOGIC EXAMINATION (performed by certified examiner)**

- 1. Eye
 

	Right	Left
a. Strabismus (any kind)	_____	_____
b. Nystagmus	_____	_____
c. Roving Eye Movements	_____	_____
1 = Yes 2 = No 3 = Suspect 4 = Untestable		
d. Tracks 180° (Record as 1, 2, or 4)	_____	_____
1 = Yes 2 = No 4 = Untestable		
e. Vision:	_____	_____

- |                                               |                                  |
|-----------------------------------------------|----------------------------------|
| 1 = Normal                                    | 4 = Blind some functional vision |
| 2 = Wears or was prescribed corrective lenses | 5 = Blind no useful vision       |
| 3 = Other abnormality                         |                                  |

2. Hearing

- a. Was a Follow-up audiologic assessment completed since initial discharge to home? Y N
  - 1) If NO, is consult pending for assessment? Y N

If YES, follow-up audiologic assessment completed, specify type of testing (2-4)

If the type of hearing exam is unknown, **skip to question 2.a.4) Unknown type of hearing test.**
  - 2) Visual Reinforcement Audiometry (VRA)? Y N

If Yes,

a. Right \_\_\_\_\_ b. Left \_\_\_\_\_ c. Sound field only \_\_\_\_\_

Results: 1=Pass 2=Fail 3=Equivocal 4=Unknown
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  - 3) Auditory Brainstem Response (ABR)? Y N

If Yes,

a. Right \_\_\_\_\_ b. Left \_\_\_\_\_

1=Pass 2=Fail 3=Equivocal 4=Unknown
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- 4) Unknown type of hearing test? Y N

If Yes,

a. Right \_\_\_\_\_ b. Left \_\_\_\_\_

1=Pass 2=Fail 3=Equivocal 4=Unknown
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- b. Hearing impaired (based on observation +/- history)? \_\_\_\_\_

1 = No apparent functional impairment +/- <b>amplification</b>
2 = Impairment +/- <b>amplification</b>

- 1) Hearing aid requirement (*use codes below*): \_\_\_\_\_

- 2) Cochlear implant requirement (*use codes below*): \_\_\_\_\_

0 = None 1 = Right only 2 = Left only 3 = Both
------------------------------------------------

- 4. Nature of motor involvement with child in any comfortable position:
  - a. Observed abnormal movements? Y N

If Yes, abnormal,

    - 1) Short -jerky Y N
    - 2) Slow, writhing? Y N
    - 3) Tremor Y N
    - 4) Ataxia Y N

- b. Passive muscle tone: (*use codes below for questions B.4.b. 2-3*)
 

1 = Normal	4 = Suspect Decreased
2 = Suspect Increased	5 = Definite Decreased
3 = Definite Increased	6 = Varying tone

- 2) Upper extremity passive muscle tone: Right Left  
\_\_\_\_\_
- 3) Lower extremity passive muscle tone: \_\_\_\_\_
  - a. Hips and knees \_\_\_\_\_
  - b. Ankles \_\_\_\_\_

- 5. Is there scissoring of the legs on vertical suspension? Y N

Complete Question 6 for all children. Examiners check one level according to the child's age. Keyers key corresponding DMS code.

### 18 Months - 21 Months 29 Days

### 22-26 Months

6. Gross Motor Function Level (18 Months - 21 Months 29 Days)	DMS Code
___ <b>Normal</b> (Walks 10 steps independently and fluently)	=1
___ <b>Possible Level I</b> (Walks 10 steps independently but not fluently; child exhibits toe walking or asymmetric walking)	=2
___ <b>Level I</b> (Moves in/out of sitting and floor-sit with both hands free to manipulate objects. Infants creep or crawl on hands and knees, pull to stand and take steps holding onto furniture. Infants walk between 18 mo and 2 years without holding on.)	=3
___ <b>Level II</b> (Maintains floor sitting but may need to use hands for support to maintain balance. Creeps on stomach or crawls on hands and knees. May pull to stand and take steps holding onto furniture)	=4
___ <b>Level III</b> (Maintains floor sitting when the low back is supported. Rolls and creeps forward on stomach)	=5
___ <b>Level IV</b> (Has head control but trunk support is required for floor sitting. Can roll to supine and may roll to prone)	=6
___ <b>Level V</b> (Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement)	=7

OR

6. Gross Motor Function Level (22-26 Months)	DMS Code
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Infants move in and out of sitting and floor sit with both hands free to manipulate objects. Infants crawl on hands and knees, pull to stand and take steps holding on to furniture. Infants walk 10 steps independently, with hands free, but with some gait abnormalities – includes toe walking, asymmetric walking, wide based gait with coordination or ataxic gait.)	=3
___ <b>Level II</b> (Infants maintain floor sitting but may need to use their hands for support to maintain balance. Infants creep on their stomach or crawl on hands and knees with reciprocal leg movement. Infants may pull to stand and take steps holding on to furniture.)	=4
___ <b>Level III</b> (Infants maintain floor sitting when the low back is supported. Infants roll and creep forward on their stomachs, or may crawl with or without reciprocal leg movements.)	=5
___ <b>Level IV</b> (Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.)	=6
___ <b>Level V</b> (Physical impairments limit voluntary control of movement. Infants are unable to maintain antigravity head and trunk postures in prone and sitting. Infants require adult assistance to roll.)	=7

↓ If > 24 Months also answer 6.a

6a. Gross Motor Function Level (>24 Months). <i>For children examined after 24 months, questions 6 and 6a should be completed.</i>	DMS Code
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Children floor sit with both hands free to manipulate objects. Movements in and out of floor sitting and standing are performed without adult assistance. Children walk as the preferred method of mobility without the need for any assistive mobility device.)	=3
___ <b>Level II</b> (Children floor sit but may have difficulty with balance when both hands are free to manipulate objects. Movements in and out of sitting are performed without adult assistance. Children pull to stand on a stable surface. Children crawl on hands and knees with a reciprocal pattern, cruise holding onto furniture and walk using an assistive mobility device as preferred methods of mobility.)	=4
___ <b>Level III</b> (Children maintain floor sitting often by "W-sitting" (sitting between flexed and internally rotated hips and knees) and may require adult assistance to assume sitting. Children creep on their stomach or crawl on hands and knees (often without reciprocal leg movements) as their primary methods of self-mobility. Children may pull to stand on a stable surface and cruise short distances. Children may walk short distances indoors using a hand-held mobility device (walker) and adult assistance for steering and turning.)	=5
___ <b>Level IV</b> (Children floor sit when placed, but are unable to maintain alignment and balance without use of their hands for support. Children frequently require adaptive equipment for sitting and standing. Self-mobility for short distances (within a room) is achieved through rolling, creeping on stomach, or crawling on hands and knees without reciprocal leg movement.)	=6
___ <b>Level V</b> (Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, children have no means of independent movement and are transported. Some children achieve self-mobility using a powered wheelchair with extensive adaptations.)	=7

7. Hand preference \_\_\_\_\_

1 = None	3 = Exaggerated Left
2 = Exaggerated Right	4 = Untestable

c. Lower limb function-gait: \_\_\_\_\_

1 = No significant problem with gait; walks fluently
2 = Gait functional but not fluent, no device required
3 = Gait functional, non-fluent and requires device or hand held
4 = No independent walking even with device or hand held

**C. REFLEXES / MOTOR SKILLS / DIAGNOSES**

1. Protective reactions (anterior, lateral and parachute) \_\_\_\_\_

1 = Symmetric	2 = Asymmetric	3 = Not present
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d. Upper limb function: \_\_\_\_\_

1 = No apparent problem with bimanual tasks
2 = Some difficulty using both hands together
3 = No functional bimanual task

2. Limb movements \_\_\_\_\_

1 = Symmetric	2 = More on right	3 = More on left
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1) Right 2) Left

a. Upper limbs \_\_\_\_\_

b. Lower limbs \_\_\_\_\_

e. Hand function: \_\_\_\_\_

1 = Fine pincer grasp	5 = Does not attempt to grasp
2 = Finger-Thumb grasp	6 = Refusal
3 = More than one finger-thumb (rake) grasp	7 = Cannot assess
4 = Tries but unable to grasp	

For questions C.3 – 5 use the following codes

1 = Normal (1 to 3+)	2 = Absent (0)	3 = Hyperactive (4+)
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Right Left

3. Deep tendon reflexes – upper extremities \_\_\_\_\_

4. Deep tendon reflexes – knees \_\_\_\_\_

5. Deep tendon reflexes – ankles \_\_\_\_\_

6. Ankle clonus \_\_\_\_\_

1 = None ( $\leq$ 4 beats)	2 = Present ( $>$ 4 beats)	3 = Sustained
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7. Plantar reflexes \_\_\_\_\_

1 = Flexor plantar response	3 = Spontaneous extension $\pm$ fanning	5 = Absent
2 = Extensor plantar response	4 = Inconsistent results	

8. Functional gross motor skills \_\_\_\_\_

a. Axis-head and neck: \_\_\_\_\_

1 = Normal head control
2 = Abnormal, but can hold head up for extended period ( $\geq$ 5 min.)
3 = Poor head control but can hold head up for short period
4 = No obvious head control

b. Axis-trunk: \_\_\_\_\_

1 = No apparent problem
2 = Can sit unsupported but less secure and stable than normal child of same age
3 = Cannot be left in sitting position unless self-supported
4 = Severe impairment: Difficult to place or maintain in sitting position

9. Diagnoses: Neurologic/Motor disorder

a. Is the neurological exam Normal? Y N

If YES, skip to question C10 (Does the child have CP?) and code NO.  
If NO, go to C.9.b.

b. Is the neurologic exam SUSPECT (suspect or definite increased or decreased tone or reflexes with **no functional impairment**)? Y N

If YES, skip to question C10 (Does the child have CP?) and code NO. If NO, go to either C.9.c or C.9d

c. If Neuro ABNORMAL (OTHER THAN CEREBRAL PALSY). **Choose only one** then skip to C10 and code NO. Finding is associated with mild, moderate or severe functional impairment. \_\_\_\_\_

1 = Hypotonia  
3 = Other  
  
If Other, describe:  
\_\_\_\_\_

d. If Neuro ABNORMAL (CEREBRAL PALSY). **Choose only one** and go to question C10 (Does the child have CP?) and code YES: \_\_\_\_\_

1 = Spastic diplegia  
2 = Spastic hemiplegia – right  
3 = Spastic hemiplegia – left  
4 = Spastic quadriplegia  
6 = Athetosis/dystonia with varying tone  
7 = Hypotonic with + ataxia  
9 = Mixed cerebral palsy  
If mixed CP, identify 2 categories from answer codes 1-7 above that reflect findings in order of prominence:  
\_\_\_\_, \_\_\_\_

10. Does this child have cerebral palsy? Y N

If YES, classification of cerebral palsy: \_\_\_\_\_

1 = Mild (GMFCS Level 1)  
2 = Moderate (GMFCS Level 2-3)  
3 = Severe (GMFCS Level 4-5)

11. Congenital and/or acquired abnormalities? Y N

11a. If YES, enter codes from Manual-App D or describe, if no codes apply:  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

1) Describe: \_\_\_\_\_

11b. If YES, does the abnormality affect neurodevelopmental assessment? Y N

**D. FORM COMPLETION**

1. Where was exam completed: \_\_\_\_\_

1 = Clinic    2 = Home    3 = Other Clinic    4 = Hospital  
9 = Other (specify): \_\_\_\_\_

2. Quality of the exam? \_\_\_\_\_

1 = Good    2 = Fair    3 = Poor

If Fair (2) or Poor (3), factors affecting the exam? \_\_\_\_\_

Codes for reasons quality of exam is Fair (2) or Poor (3):  
1 = Illness  
2 = Language other than English and interpreter not available  
3 = Behavioral problems  
4 = Severely developmentally delayed plus may have sensory impairment (Bayley score of 49)  
5 = Sensory impairment - appears mild or moderately delayed for age  
6 = Sensory impairment - but appears to be within normal limits for age  
9 = Other: (Specify) \_\_\_\_\_

3. Date exam completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

4. Initials of person administering Infant examination: \_\_\_\_\_

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ (optional) Follow-up No.: \_\_\_\_\_

**Use this worksheet to determine the answer for NF05 question B6, *Gross Motor Function Level for children age 18 Months – 21 Months 29 Days.***

Walks 10 steps independently? No    Yes	If Yes, →	Normal gait? No    Yes	If Yes, →	<b>Normal</b> If No, → <b>Possible Level 1</b>
If No, ↓				
Sits, hands free for play? No    Yes	If Yes, →	Creeps or crawls on hands & knees, pulls to stand; cruises and walks with hands held? No    Yes	If Yes, →	<b>Level 1</b> If No, → <b>Level 2</b>
If No, ↓				
Uses hands for sitting support; creeps on stomach or crawls, may cruise/pull to stand? No    Yes	If Yes, →	<b>Level 2</b>		
If No, ↓				
Sits with external support for lower trunk; rolls, creeps on stomach? No    Yes	If Yes, →	<b>Level 3</b>		
If No, ↓				
Good head control in supported sitting; can roll to supine, may roll to prone? No    Yes	If Yes, →	<b>Level 4</b>		
If No, ↓				
Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement.	If Yes, →	<b>Level 5</b>		

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ (optional) Follow-up No.: \_\_\_\_\_

11/21/2014  
Page 2 of 3

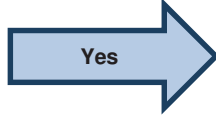
Use this worksheet to determine the answer for NF05 question B6, *Gross Motor Function Level for children age 22-26 Months.*

<p>Walks independently (i.e. <math>\geq 10</math> steps), with normal and fluent gait?</p> <p style="text-align: center;">No    Yes</p>	If Yes, →	<p><b>Normal (Level 0)</b></p>
If No, ↓		
<p>Moves in and out of sitting and floor sit with both hands free to manipulate objects?</p> <p style="text-align: center;">No    Yes</p>	If Yes, →	<p>Crawls on hands &amp; knees, pulls to stand, takes steps holding onto furniture. Walks independently with hands free (even if has some gait abnormalities)?</p> <p style="text-align: center;">No    Yes</p>
If Yes, → <b>Level 1</b>		
If No, → <b>Level 2</b>		
If No, ↓		
<p>Maintains floor sitting* but needs to use one or both hands for support to maintain balance?</p> <p style="text-align: center;">No    Yes</p>	If Yes, →	<p>Creeps on stomach or crawls on hands and knees with reciprocal leg movement. Pulls to stand and takes steps holding onto furniture.</p> <p style="text-align: center;">No    Yes</p>
If Yes, → <b>Level 2</b>		
If No, → <b>Level 3</b>		
If No, ↓		
<p>Maintains floor sitting* when the low back is supported?</p> <p style="text-align: center;">No    Yes</p>	If Yes, →	<p>Rolls and creeps forward on stomach, or crawls with or without reciprocal leg movements.</p> <p style="text-align: center;">No    Yes</p>
If Yes, → <b>Level 3</b>		
If No, → <b>Level 4</b>		
If No, ↓		
<p>Has head control but trunk support is required for floor sitting?</p> <p style="text-align: center;">No    Yes</p>	If Yes, →	<p>Can roll to supine (and may roll to prone).</p> <p style="text-align: center;">No    Yes</p>
If Yes, → <b>Level 4</b>		
If No, → <b>Level 5</b>		
If No, ↓		
<p>Physical impairments limit voluntary control of movement. Unable to maintain antigravity head and trunk postures in prone and sitting. Infants require adult assistance to roll.</p>		If Yes, → <b>Level 5</b>

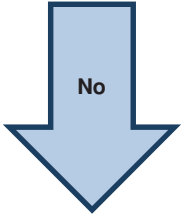
\*Floor sitting: legs must be outstretched (rather than hanging over table/chair edge or in w-position)

Use this worksheet to determine the answer for NF05 question C9 Diagnoses: Neurologic/Motor disorder.

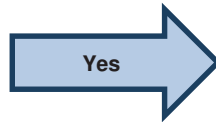
Is the neuro exam normal?



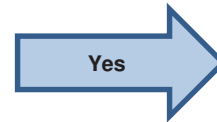
Code 9a. Neuro Normal=Yes  
Code C10. CP=No



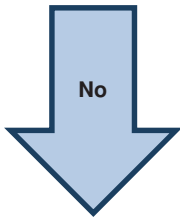
Is there functional impairment?



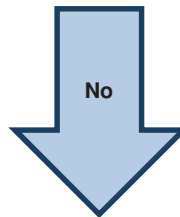
Does the child have CP?



Select type of CP in 9d. Neuro Abnormal-CP  
Code C10. CP=Yes



Code 9b. Neuro exam Suspect=Yes  
Code C10. CP=No



Code 9c. Neuro abnormal – Other than CP  
as Hypotonia or Other (describe)  
Code C10. CP=No



This form should be completed by examiners for each exam included on the annual certification DVD for the Follow-up Study neurological exam.

**A. PHYSICAL EXAMINATION**

- 1. Weight: \_\_\_\_\_ kg
- 2. Recumbent length: \_\_\_\_\_ cm
- 3. Occipital-frontal circumference: \_\_\_\_\_ cm

**B. NEUROLOGIC EXAMINATION (performed by certified examiner)**

- 1. Eye
 

	Right	Left
a. Strabismus (any kind)	___	___
b. Nystagmus	___	___
c. Roving Eye Movements	___	___
1 = Yes 2 = No 3 = Suspect 4 = Untestable		
d. Tracks 180° (Record as 1, 2, or 4)	___	___
1 = Yes 2 = No 4 = Untestable		
e. Vision:	___	___

- |                                               |                                  |
|-----------------------------------------------|----------------------------------|
| 1 = Normal                                    | 4 = Blind some functional vision |
| 2 = Wears or was prescribed corrective lenses | 5 = Blind no useful vision       |
| 3 = Other abnormality                         |                                  |

- 2. Hearing
  - a. Was a Follow-up audiologic assessment completed since initial discharge to home? Y N
  - 1) If NO, is consult pending for assessment? Y N  
If YES, follow-up audiologic assessment completed, specify type of testing (2-4)  
If the type of hearing exam is unknown, **skip to question 2.a.4) Unknown type of hearing test.**
  - 2) Visual Reinforcement Audiometry (VRA)? Y N  
If Yes,  
a. Right \_\_\_ b. Left \_\_\_ c. Sound field only \_\_\_  

Results: 1=Pass 2=Fail 3=Equivocal 4=Unknown
----------------------------------------------
  - 3) Auditory Brainstem Response (ABR)? Y N  
If Yes,  
a. Right \_\_\_ b. Left \_\_\_  

1=Pass 2=Fail 3=Equivocal 4=Unknown
-------------------------------------

- 4) Unknown type of hearing test? Y N  
If Yes,  
a. Right \_\_\_ b. Left \_\_\_

1=Pass 2=Fail 3=Equivocal 4=Unknown
-------------------------------------

- b. Hearing impaired (based on observation +/- history)? \_\_\_  

1 = No apparent functional impairment +/- <b>amplification</b> 2 = Impairment +/- <b>amplification</b>
-----------------------------------------------------------------------------------------------------------

- 1) Hearing aid requirement (*use codes below*): \_\_\_
- 2) Cochlear implant requirement (*use codes below*): \_\_\_  

0 = None 1 = Right only 2 = Left only 3 = Both
------------------------------------------------

- 4. Nature of motor involvement with child in any comfortable position:
  - a. Observed abnormal movements? Y N  
If Yes, abnormal,
    - 1) Short -jerky Y N
    - 2) Slow, writhing? Y N
    - 3) Tremor Y N
    - 4) Ataxia Y N

- b. Passive muscle tone: (*use codes below for questions B.4.b. 2-3*)
 

1 = Normal	4 = Suspect Decreased
2 = Suspect Increased	5 = Definite Decreased
3 = Definite Increased	6 = Varying tone

- 2) Upper extremity passive muscle tone: Right Left  
\_\_\_ \_\_\_
- 3) Lower extremity passive muscle tone: \_\_\_ \_\_\_
  - a. Hips and knees
  - b. Ankles

- 5. Is there scissoring of the legs on vertical suspension? Y N

Complete Question 6 for all children. Examiners check one level according to the child's age. Keyers key corresponding DMS code.

### 18 Months - 21 Months 29 Days

### 22-26 Months

6. Gross Motor Function Level (18 Months - 21 Months 29 Days)	DMS Code
___ <b>Normal</b> (Walks 10 steps independently and fluently)	=1
___ <b>Possible Level I</b> (Walks 10 steps independently but not fluently; child exhibits toe walking or asymmetric walking)	=2
___ <b>Level I</b> (Moves in/out of sitting and floor-sit with both hands free to manipulate objects. Infants creep or crawl on hands and knees, pull to stand and take steps holding onto furniture. Infants walk between 18 mo and 2 years without holding on.)	=3
___ <b>Level II</b> (Maintains floor sitting but may need to use hands for support to maintain balance. Creeps on stomach or crawls on hands and knees. May pull to stand and take steps holding onto furniture)	=4
___ <b>Level III</b> (Maintains floor sitting when the low back is supported. Rolls and creeps forward on stomach)	=5
___ <b>Level IV</b> (Has head control but trunk support is required for floor sitting. Can roll to supine and may roll to prone)	=6
___ <b>Level V</b> (Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement)	=7

OR

6. Gross Motor Function Level (22-26 Months)	DMS Code
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Infants move in and out of sitting and floor sit with both hands free to manipulate objects. Infants crawl on hands and knees, pull to stand and take steps holding on to furniture. Infants walk 10 steps independently, with hands free, but with some gait abnormalities – includes toe walking, asymmetric walking, wide based gait with coordination or ataxic gait.)	=3
___ <b>Level II</b> (Infants maintain floor sitting but may need to use their hands for support to maintain balance. Infants creep on their stomach or crawl on hands and knees with reciprocal leg movement. Infants may pull to stand and take steps holding on to furniture.)	=4
___ <b>Level III</b> (Infants maintain floor sitting when the low back is supported. Infants roll and creep forward on their stomachs, or may crawl with or without reciprocal leg movements.)	=5
___ <b>Level IV</b> (Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.)	=6
___ <b>Level V</b> (Physical impairments limit voluntary control of movement. Infants are unable to maintain antigravity head and trunk postures in prone and sitting. Infants require adult assistance to roll.)	=7

↓ If > 24 Months also answer 6.a

6a. Gross Motor Function Level (>24 Months). <i>For children examined after 24 months, questions 6 and 6a should be completed.</i>	DMS Code
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Children floor sit with both hands free to manipulate objects. Movements in and out of floor sitting and standing are performed without adult assistance. Children walk as the preferred method of mobility without the need for any assistive mobility device.)	=3
___ <b>Level II</b> (Children floor sit but may have difficulty with balance when both hands are free to manipulate objects. Movements in and out of sitting are performed without adult assistance. Children pull to stand on a stable surface. Children crawl on hands and knees with a reciprocal pattern, cruise holding onto furniture and walk using an assistive mobility device as preferred methods of mobility.)	=4
___ <b>Level III</b> (Children maintain floor sitting often by "W-sitting" (sitting between flexed and internally rotated hips and knees) and may require adult assistance to assume sitting. Children creep on their stomach or crawl on hands and knees (often without reciprocal leg movements) as their primary methods of self-mobility. Children may pull to stand on a stable surface and cruise short distances. Children may walk short distances indoors using a hand-held mobility device (walker) and adult assistance for steering and turning.)	=5
___ <b>Level IV</b> (Children floor sit when placed, but are unable to maintain alignment and balance without use of their hands for support. Children frequently require adaptive equipment for sitting and standing. Self-mobility for short distances (within a room) is achieved through rolling, creeping on stomach, or crawling on hands and knees without reciprocal leg movement.	=6
___ <b>Level V</b> (Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, children have no means of independent movement and are transported. Some children achieve self-mobility using a powered wheelchair with extensive adaptations.)	=7

7. Hand preference \_\_\_\_\_

1 = None	3 = Exaggerated Left
2 = Exaggerated Right	4 = Untestable

c. Lower limb function-gait: \_\_\_\_\_

1 = No significant problem with gait; walks fluently
2 = Gait functional but not fluent, no device required
3 = Gait functional, non-fluent and requires device or hand held
4 = No independent walking even with device or hand held

**C. REFLEXES / MOTOR SKILLS / DIAGNOSES**

1. Protective reactions (anterior, lateral and parachute) \_\_\_\_\_

1 = Symmetric	2 = Asymmetric	3 = Not present
---------------	----------------	-----------------

d. Upper limb function: \_\_\_\_\_

1 = No apparent problem with bimanual tasks
2 = Some difficulty using both hands together
3 = No functional bimanual task

2. Limb movements \_\_\_\_\_

1 = Symmetric	2 = More on right	3 = More on left
---------------	-------------------	------------------

1) Right 2) Left

a. Upper limbs \_\_\_\_\_

b. Lower limbs \_\_\_\_\_

e. Hand function: \_\_\_\_\_

1 = Fine pincer grasp	5 = Does not attempt to grasp
2 = Finger-Thumb grasp	6 = Refusal
3 = More than one finger-thumb (rake) grasp	7 = Cannot assess
4 = Tries but unable to grasp	

For questions C.3 – 5 use the following codes

1 = Normal (1 to 3+)	2 = Absent (0)	3 = Hyperactive (4+)
----------------------	----------------	----------------------

Right Left

3. Deep tendon reflexes – upper extremities \_\_\_\_\_

4. Deep tendon reflexes – knees \_\_\_\_\_

5. Deep tendon reflexes – ankles \_\_\_\_\_

6. Ankle clonus \_\_\_\_\_

1 = None ( $\leq$ 4 beats)	2 = Present ( $>$ 4 beats)	3 = Sustained
----------------------------	----------------------------	---------------

7. Plantar reflexes \_\_\_\_\_

1 = Flexor plantar response	3 = Spontaneous extension $\pm$ fanning	5 = Absent
2 = Extensor plantar response	4 = Inconsistent results	

8. Functional gross motor skills \_\_\_\_\_

a. Axis-head and neck: \_\_\_\_\_

1 = Normal head control
2 = Abnormal, but can hold head up for extended period ( $\geq$ 5 min.)
3 = Poor head control but can hold head up for short period
4 = No obvious head control

b. Axis-trunk: \_\_\_\_\_

1 = No apparent problem
2 = Can sit unsupported but less secure and stable than normal child of same age
3 = Cannot be left in sitting position unless self-supported
4 = Severe impairment: Difficult to place or maintain in sitting position

9. Diagnoses: Neurologic/Motor disorder

a. Is the neurological exam Normal? Y N

*If YES, skip to question C10 (Does the child have CP?) and code NO.*

*If NO, go to C.9.b.*

b. Is the neurologic exam SUSPECT (suspect or definite increased or decreased tone or reflexes with **no functional impairment**)? Y N

*If YES, skip to question C10 (Does the child have CP?) and code NO. If NO, go to either C.9.c or C.9d*

c. If Neuro ABNORMAL (OTHER THAN CEREBRAL PALSY). **Choose only one** then skip to C10 and code NO. Finding is associated with mild, moderate or severe functional impairment. \_\_\_\_\_

1 = Hypotonia  
 3 = Other  
 If Other, describe:  
 \_\_\_\_\_

d. If Neuro ABNORMAL (CEREBRAL PALSY). **Choose only one** and go to question C10 (Does the child have CP?) and code YES: \_\_\_\_\_

1 = Spastic diplegia  
 2 = Spastic hemiplegia – right  
 3 = Spastic hemiplegia – left  
 4 = Spastic quadriplegia  
 6 = Athetosis/dystonia with varying tone  
 7 = Hypotonic with + ataxia  
 9 = Mixed cerebral palsy  
 If mixed CP, identify 2 categories from answer codes 1-7 above that reflect findings in order of prominence:  
 \_\_\_\_\_, \_\_\_\_\_

10. Does this child have cerebral palsy? Y N

If YES, classification of cerebral palsy: \_\_\_\_\_

1 = Mild (GMFCS Level 1)  
 2 = Moderate (GMFCS Level 2-3)  
 3 = Severe (GMFCS Level 4-5)

11. Congenital and/or acquired abnormalities? Y N

11a. If YES, enter codes from Manual-App D or describe, if no codes apply:  
 \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

1) Describe: \_\_\_\_\_

11b. If YES, does the abnormality affect neurodevelopmental assessment? Y N

**D. FORM COMPLETION**

1. Where was exam completed: \_\_\_\_\_

1 = Clinic    2 = Home    3 = Other Clinic    4 = Hospital  
 9 = Other (specify): \_\_\_\_\_

2. Quality of the exam? \_\_\_\_\_

1 = Good    2 = Fair    3 = Poor

If Fair (2) or Poor (3), factors affecting the exam? \_\_\_\_\_

Codes for reasons quality of exam is Fair (2) or Poor (3):  
 1 = Illness  
 2 = Language other than English and interpreter not available  
 3 = Behavioral problems  
 4 = Severely developmentally delayed plus may have sensory impairment (Bayley score of 49)  
 5 = Sensory impairment - appears mild or moderately delayed for age  
 6 = Sensory impairment - but appears to be within normal limits for age  
 9 = Other: (Specify) \_\_\_\_\_

3. Date exam scored: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year

4. Initials of person scoring exam: \_\_\_\_\_

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**This form should be completed for all children who have taken the Bayley III exam at the Follow-up visit. Record the scores for adjusted age.**

**A. Bayley III Information**

1. Was the child successfully tested for the following?
  - a. Cognitive Subtest: Y    N  
 1. If NO, reason not successfully tested (see codes below) \_\_\_\_\_  
 a. if coded as 9, "Other", specify reason:  
 \_\_\_\_\_
  - b. Language (Receptive Communication) Subtest: Y    N  
 1. If NO, reason not successfully tested (see codes below) \_\_\_\_\_  
 a. if coded as 9, "Other", specify reason:  
 \_\_\_\_\_
  - c. Language (Expressive Communication) Subtest: Y    N  
 1. If NO, reason not successfully tested (see codes below) \_\_\_\_\_  
 a. if coded as 9, "Other", specify reason:  
 \_\_\_\_\_
  - d. Motor (Fine) Subtest Y    N  
 1. If NO, reason not successfully tested (see codes below) \_\_\_\_\_  
 a. if coded as 9, "Other", specify reason:  
 \_\_\_\_\_
  - e. Motor (Gross) Subtest Y    N  
 1. If NO, reason not successfully tested (see codes below) \_\_\_\_\_  
 a. if coded as 9, "Other", specify reason:  
 \_\_\_\_\_

2. Adjusted age for Receptive Communication \_\_\_\_  
Months
3. Adjusted age for Expressive Communication \_\_\_\_  
Months
4. Adjusted age for Motor (Fine) subtest \_\_\_\_  
Months
5. Adjusted age for Motor (Gross) subtest \_\_\_\_  
Months

	Raw	Scaled Score
g. Bayley Scales of Infant Development		
1. Cognitive	____	____
2. Cognitive Composite Score	____	____
3. Receptive	____	____
4. Expressive	____	____
5. Summed Language Score (Scaled Receptive + Scaled Expressive)	____	____
6. Language Composite	____	____
	Raw	Scaled Score
7. Fine Motor	____	____
8. Gross Motor	____	____
9. Summed Motor Score (Scaled Fine & Gross)	____	____
10. Motor composite	____	____
h. Was the Bayley Exam conducted in English? <span style="float: right;">Y    N</span>		
1. If NO, was an interpreter required? <span style="float: right;">Y    N</span>		
i. Was the Bayley administrator masked to the child's medical history? <span style="float: right;">Y    N</span>		

Codes for reasons not successfully tested  
 1 = Illness  
 2 = Language other than English and interpreter not available  
 3 = Behavioral problems  
 4 = Severely developmentally delayed, and/or legally blind and/or profound hearing loss - assigned a composite score of 54 for Cognitive, 46 for Language, 46 for Motor  
 5 = Severe cerebral palsy  
 6 = anatomic abnormalities of hands/feet i.e. club feet, dislocated hips, arthrogryposis  
 9 = Other (i.e. children in body cast, children who are absent extremities)

Complete items f - i if successfully tested or severely developmentally delayed (Code 4)

- f. Adjusted age
  1. Adjusted age for Cognitive subtest \_\_\_\_  
Months

**B. Form Completion**

1. Where was the Bayley III exam completed? \_\_\_\_\_  

1 = Clinic	3 = Other Clinic	9 = Other
2 = Home	4 = Hospital	
2. Date the Bayley III exam was completed? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year
3. Initials of person administering Bayley III exam \_\_\_\_\_



Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**This form should be keyed and sent to RTI via weekly data transmission if any of the items listed below are missing on the NF05 or NF09A**

*Specify reasons for **incomplete** items on the NF05 and NF09A.*

**A. NF05 Items:**

1. B6-Current Gross Motor Function

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

2. A1-Weight

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

3. A2-Recumbent Length

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

4. B1a-Strabismus Right and/or Left

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

5. B1b-Nystagmus Right and/or Left

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

6. B1c-Roving Eye Right and/or Left

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

7. B1d-Tracks Right and/or Left

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

8. B1e-Vision Right and/or Left

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

9. B2b-Hearing Impaired

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

10. B3a-Swallowing

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

11. B4a-Abnormal Movements at Rest

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

12. C8a-Motor Skill: Axis Head and Neck

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

13. C8b-Motor Skill: Axis-Trunk

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

14. C8c-Motor Skill: Lower Limb function

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

15. C8d-Motor Skill: Upper Limb Function

Indicate reason: \_\_\_\_\_

16. C8e-Hand Function Right and/or Left

Indicate reason: \_\_\_\_\_

17. C9a-Normal Neurologic/Motor

Indicate reason: \_\_\_\_\_  
\_\_\_\_\_

18. C10-Does Child Have Cerebral Palsy

Indicate reason: \_\_\_\_\_

19. C11-Congenital/Acquired Abnormalities

Indicate reason: \_\_\_\_\_

**C. NF09A (Bayley III) Items:**

1. A1a1-Unsuccessfully Tested for Cognitive or not tested because of reason 1, 2, 3 or 9?

Indicate reason: \_\_\_\_\_

2. A1b1-Unsuccessfully Tested for Receptive Communication or not tested because of reason 1, 2, 3 or 9?

Indicate reason: \_\_\_\_\_

3. A1c1-Unsuccessfully Tested for Expressive Communication or not tested because of reason 1, 2, 3 or 9?

Indicate reason: \_\_\_\_\_

4. A1d1-Unsuccessfully Tested for Fine Motor or not tested because of reason 1, 2, 3, 5, 6, or 9.

Indicate reason: \_\_\_\_\_

5. A1e1-Unsuccessfully Tested for Gross Motor or not tested because of reason 1, 2, 3, 5, 6, or 9.

Indicate reason: \_\_\_\_\_

**D. NDI Assessment**

1. In your best clinical judgment would you classify the child as:

	<u>Clinical Judgment</u>	<u>Source</u>
a. Moderate to severe CP with GMFCS level >=2	_____	_____
b. BayleyIII Motor score <70	_____	_____
c. Bayley III Cognitive score <70	_____	_____
d. Bilateral blindness (<20-200)	_____	_____
e. Hearing impaired ± amplification	_____	_____

**Clinical Judgment CODES** 1=Yes, 2=No, 3=Suspect, 4=Can't be determined

**Source CODES** 1=Chart Review, 2=Physician Report, 3=Caretaker interview

**F. Form Completion**

1. Date form completed: \_\_\_/\_\_\_/\_\_\_ (month/day/year)

2. Initials of person completing this form: \_\_\_\_\_

Center: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Site No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

Page 1 of 1

**This form should be completed for all children when the Follow-up visit has been completed.****A. IDENTIFICATION INFORMATION**

## 1. Visit date(s)

a. Date of first visit: \_\_\_/\_\_\_/\_\_\_

Month Day Year

b. Date of final visit: \_\_\_/\_\_\_/\_\_\_

Month Day Year

**B. ASSESSMENT INFORMATION**

1. Identification Information (NF00)?

Done

Y N

2. SES at Discharge (NF01)?

Y N

3. SES at Follow-up (NF03)?

Y N

4. Medical History Form (NF04)?

Y N

a. Readmission Form (NF04A)

Y N

5. Child Examination Form (NF05)?

Y N

7. Status Form (NF10)?

Y N

8. Lost to Follow-up Questionnaire (NF12)?

Y N

9. BITSEA Questionnaire (NF13)?

Y N

10. Bayley III Scales Summary Score Sheet (NF09A)?

Y N

11. Child Behavior Checklist (CBCL)?

Y N

**C. FORM COMPLETION**

## 1. Date form completed:

\_\_\_/\_\_\_/\_\_\_

Month Day Year

## 3. Initials of person completing this form: \_\_\_\_\_





Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

12. Has a doctor ever said that (name) \_\_\_\_\_ has:
- |                                                                                                                      |       |   |
|----------------------------------------------------------------------------------------------------------------------|-------|---|
| a. Hydrocephalus treated with a shunt?                                                                               | Y     | N |
| b. Cerebral Palsy?                                                                                                   | Y     | N |
| c. Developmental delay?                                                                                              | Y     | N |
| d. Language delay?                                                                                                   | Y     | N |
| e. Poor weight gain?                                                                                                 | Y     | N |
| f. Seizures since discharge?                                                                                         | Y     | N |
| g. Blindness (legally blind)?                                                                                        | Y     | N |
| h. Other behavior problems                                                                                           | Y     | N |
| 1. If Yes, Describe _____                                                                                            |       |   |
| i. Other major medical problems                                                                                      | Y     | N |
| 1. If Yes, Describe _____                                                                                            |       |   |
| j. Other neurodevelopmental problem?                                                                                 | Y     | N |
| 1. If Yes, Describe _____                                                                                            |       |   |
| k. Deafness?                                                                                                         | Y     | N |
| l. Gross Motor Function Level from caretaker interview<br>(See Pg 4 for GMFCS descriptions according to child's age) | _____ |   |
- |                        |               |             |
|------------------------|---------------|-------------|
| 1 = Normal (Level '0') | 4 = Level II  | 7 = Level V |
| 2 = Possible Level I   | 5 = Level III |             |
| 3 = Level I            | 6 = Level IV  |             |
1. **If >24 months**, also answer B.12.I.1 \_\_\_\_\_  
(See Pg 4 for >24 months GMFCS descriptions)
- |                        |               |             |
|------------------------|---------------|-------------|
| 1 = Normal (Level '0') | 4 = Level II  | 7 = Level V |
| 3 = Level I            | 5 = Level III |             |
|                        | 6 = Level IV  |             |

13. Initials of interviewer: \_\_\_ \_\_\_

With permission of interviewee, complete the following forms:

- **Medical History – Form NF04**
- **Rehospitalization – NF04A, if necessary**
- **SES – Form NF03**

**C. CHART REVIEW INFORMATION OR REPORT FROM PHYSICIAN**

Chart review information — Complete if items were not obtained by interview.

1=Yes	2=No	3=Unknown
-------	------	-----------

- |                                                                       |       |
|-----------------------------------------------------------------------|-------|
| 1. Has the child had an eye exam since initial discharge:             | _____ |
| 2. Has the child had a hearing exam since initial discharge:          | _____ |
| 3. Does the child need or wear a hearing aid(s):                      | _____ |
| 4. Did the child have any of the following based on chart review::    |       |
| a. Hydrocephalus treated with a shunt?                                | _____ |
| b. Cerebral Palsy?                                                    | _____ |
| c. Developmental delay?                                               | _____ |
| d. Language delay?                                                    | _____ |
| e. Poor weight gain?                                                  | _____ |
| f. Seizures since discharge?                                          | _____ |
| g. Blindness (legally blind)?                                         | _____ |
| h. Other behavior problems                                            | _____ |
| 1. If Yes, Describe _____                                             |       |
| i. Other major medical problems                                       | _____ |
| 1. If Yes, Describe _____                                             |       |
| j. Other neurodevelopmental problem?                                  | _____ |
| 1. If Yes, Describe _____                                             |       |
| k. Deafness?                                                          | _____ |
| l. Gross Motor Function Level from chart review/report from physician | _____ |
- (See Pg 4 for GMFCS descriptions according to child's age)
- |                        |               |             |
|------------------------|---------------|-------------|
| 1 = Normal (Level '0') | 4 = Level II  | 7 = Level V |
| 2 = Possible Level I   | 5 = Level III |             |
| 3 = Level I            | 6 = Level IV  |             |
1. **If >24 months**, also answer C.4.I.1 \_\_\_\_\_  
(See Pg 4 for >24 months GMFCS descriptions)
- |                        |               |             |
|------------------------|---------------|-------------|
| 1 = Normal (Level '0') | 4 = Level II  | 7 = Level V |
| 3 = Level I            | 5 = Level III |             |
|                        | 6 = Level IV  |             |

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**D. NDI ASSESSMENT**

**Clinical Judgment CODES:** 1=Yes, 2=No, 3=Suspect, 4=Can't be determined

**Source CODES:** 1=Chart Review, 2=Physician Report, 3=Caretaker Interview

- | 1. In your best clinical judgment would you classify the child as: | <u>Clinical Judgment</u> | <u>Source</u> |
|--------------------------------------------------------------------|--------------------------|---------------|
| a. Moderate to severe CP with GMFCS level $\geq 2$                 | _____                    | _____         |
| b. BayleyIII Motor score $< 70$                                    | _____                    | _____         |
| c. Bayley III Cognitive score $< 70$                               | _____                    | _____         |
| d. Bilateral blindness ( $< 20-200$ )                              | _____                    | _____         |
| e. Hearing impaired $\pm$ amplification                            | _____                    | _____         |

2. Initials of person completing this form: \_\_\_\_\_

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

**GMFCS level descriptions according to the child's age for questions B.12.I and C.4.I.**

<b>Gross Motor Function Level (18 Months - 21 Months 29 Days)</b>	<b>DMS Code</b>
___ <b>Normal</b> (Walks 10 steps independently and fluently)	=1
___ <b>Possible Level I</b> (Walks 10 steps independently but not fluently; child exhibits toe walking or asymmetric walking)	=2
___ <b>Level I</b> (Moves in/out of sitting and floor-sit with both hands free to manipulate objects. Infants creep or crawl on hands and knees, pull to stand and take steps holding onto furniture. Infants walk between 18 mo and 2 years without holding on.)	=3
___ <b>Level II</b> (Maintains floor sitting but may need to use hands for support to maintain balance. Creeps on stomach or crawls on hands and knees. May pull to stand and take steps holding onto furniture)	=4
___ <b>Level III</b> (Maintains floor sitting when the low back is supported. Rolls and creeps forward on stomach)	=5
___ <b>Level IV</b> (Has head control but trunk support is required for floor sitting. Can roll to supine and may roll to prone)	=6
___ <b>Level V</b> (Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement)	=7

OR

<b>Gross Motor Function Level (22-26 Months)</b>	<b>DMS Code</b>
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Infants move in and out of sitting and floor sit with both hands free to manipulate objects. Infants crawl on hands and knees, pull to stand and take steps holding on to furniture. Infants walk 10 steps independently, with hands free, but with some gait abnormalities – includes toe walking, asymmetric walking, wide based gait with coordination or ataxic gait.)	=3
___ <b>Level II</b> (Infants maintain floor sitting but may need to use their hands for support to maintain balance. Infants creep on their stomach or crawl on hands and knees with reciprocal leg movement. Infants may pull to stand and take steps holding on to furniture.)	=4
___ <b>Level III</b> (Infants maintain floor sitting when the low back is supported. Infants roll and creep forward on their stomachs, or may crawl with or without reciprocal leg movements.)	=5
___ <b>Level IV</b> (Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.)	=6
___ <b>Level V</b> (Physical impairments limit voluntary control of movement. Infants are unable to maintain antigravity head and trunk postures in prone and sitting. Infants require adult assistance to roll.)	=7

↓ **If > 24 Months also answer**

<b>Gross Motor Function Level (&gt;24 Months). <i>For children &gt; 24 months, questions B.12.I.1 and/or C.4.I.1 should also be completed.</i></b>	<b>DMS Code</b>
___ <b>Level "0"</b> (Walks independently, normal and fluent gait)	=1
___ <b>Level I</b> (Children floor sit with both hands free to manipulate objects. Movements in and out of floor sitting and standing are performed without adult assistance. Children walk as the preferred method of mobility without the need for any assistive mobility device.)	=3
___ <b>Level II</b> (Children floor sit but may have difficulty with balance when both hands are free to manipulate objects. Movements in and out of sitting are performed without adult assistance. Children pull to stand on a stable surface. Children crawl on hands and knees with a reciprocal pattern, cruise holding onto furniture and walk using an assistive mobility device as preferred methods of mobility.)	=4
___ <b>Level III</b> (Children maintain floor sitting often by "W-sitting" (sitting between flexed and internally rotated hips and knees) and may require adult assistance to assume sitting. Children creep on their stomach or crawl on hands and knees (often without reciprocal leg movements) as their primary methods of self-mobility. Children may pull to stand on a stable surface and cruise short distances. Children may walk short distances indoors using a hand-held mobility device (walker) and adult assistance for steering and turning.)	=5
___ <b>Level IV</b> (Children floor sit when placed, but are unable to maintain alignment and balance without use of their hands for support. Children frequently require adaptive equipment for sitting and standing. Self-mobility for short distances (within a room) is achieved through rolling, creeping on stomach, or crawling on hands and knees without reciprocal leg movement.)	=6
___ <b>Level V</b> (Physical impairments restrict voluntary control of movement and the ability to maintain antigravity head and trunk postures. All areas of motor function are limited. Functional limitations in sitting and standing are not fully compensated for through the use of adaptive equipment and assistive technology. At Level V, children have no means of independent movement and are transported. Some children achieve self-mobility using a powered wheelchair with extensive adaptations.)	=7

Center: \_\_\_ Site No: \_\_\_ Network No: \_\_\_\_\_ Birth No: \_\_\_ Mother's Initials: \_\_\_\_\_ Follow-up No.: \_\_\_\_\_

This form should be completed for all children at the 22-26 month Follow-up visit who are less than or equal to 26 completed weeks GA (up to and including 26 6/7 weeks).

**A. Identification**

<b>1. Date CBCL administered:</b> ____/____/____ Month Day Year	<b>4. How was CBCL administered?</b> 1=Self-administered during visit      3=Administered by clinic staff during visit 2=Self-administered prior to/after visit      4=Administered by clinic staff by phone
<b>2. Relationship of respondent to child:</b> (See Relationship Codes—if biological mother, code is 001)      ____	<b>5. Language CBCL was administered?</b> 1= English      2=Spanish      3=Other, specify _____
<b>3. Child's sex:</b> M      F	<b>6. Initials of person completing Summary Score Sheet:</b> ____

**B. Syndrome Scale Scores**

	a. Emotionally Reactive	b. Anxious/Depressed	c. Somatic Complaints	d. Withdrawn	e. Sleep Problems	f. Attention Problems	g. Aggressive Behavior
<b>1. Total Score</b>	____	____	____	____	____	____	____
<b>2. T Score</b>	_____	_____	_____	_____	_____	_____	_____
<b>3. Percentile</b>	____	____	____	____	____	____	____

**C. Internalizing, Externalizing, and Total Problems**

	a. Internalizing Problems	b. Externalizing Problems	c. Total Problems
<b>1. Total Score</b>	____	____	_____
<b>2. T Score</b>	_____	_____	_____
<b>3. Percentile</b>	____	____	____

**D. DSM-Oriented Scales**

	a. Affective Problems	b. Anxiety Problems	c. Pervasive Developmental Problems	d. Attention Deficit/Hyperactivity Problems	e. Oppositional Defiant Problems
<b>1. Total Score</b>	____	____	____	____	____
<b>2. T Score</b>	_____	_____	_____	_____	_____
<b>3. Percentile</b>	____	____	____	____	____

For percentile scores >97, record 98. For percentile scores <=50, record 49.