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: ___ ___ ___ ___ ___ ___

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=< 7th grade	5=Partial college
2=7th to 9th grade	6=College degree
3=10th to 12th 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: ___ ___ ___

NICU Network

FOLLOW-UP STUDY
VISIT LOG (NF02)

NF02 Rel 3.2
April 1, 2011

Center: __ __ **Site:** __ Page __of __

Child's Name Last	First	Date of Birth Month / Day / Year	Date of Visit Month / Day / Year	Network Number	Mother's Initials	Birth No.	Follow-up Number	Comments
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	
__________________	_________	__ __/__ __/__ __ __ __	__ __/__ __/__ __ __ __	__ __ __ __ __ __ __	__ __ __	___	__ __ __ __	

<----------Cover this before photocopying------->

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=< 7th grade	5=Partial college
2=7th to 9th grade	6=College degree
3=10th to 12th 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 ___

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

   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

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

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

   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, Y N
    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

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

PRIMARY CAUSE CODES

1 = Respiratory
2 = CNS
3 = Surgery
4 = Infection
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	___	___
d. Tracks 180º (Record as 1, 2, or 4)	___	___
e. Vision:	___	___

1 = Yes 2 = No 3 = Suspect 4 = Untestable

1 = Yes 2 = No 4 = Untestable

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

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 the results of testing

a. Right ___ b. Left ___

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

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

1 = No apparent functional impairment **+/- amplification**
2 = Impairment **+/- amplification**

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

	Right	Left
2) Upper extremity passive muscle tone:	____	____
3) Lower extremity passive muscle tone:		
a. Hips: abduction	____	____
b. Ankles: dorsiflexion	____	____
c. Knees: popliteal	____	____
d. Hips: heel ear	____	____

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

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

6. Gross Motor Function Level (18 Months - 21 Months 29 Days)

	DMS Code
___ **Normal** (Walks 10 steps independently and fluently)	=1
___ **Possible Level I** (Walks 10 steps independently but not fluently; child exhibits toe walking or asymmetric walking)	=2
___ **Level I** (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
___ **Level II** (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
___ **Level III** (Maintains floor sitting when the low back is supported. Rolls and creeps forward on stomach)	=5
___ **Level IV** (Has head control but trunk support is required for floor sitting. Can roll to supine and may roll to prone)	=6
___ **Level V** (Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement)	=7

OR

22-26 Months

6. Gross Motor Function Level (22-26 Months)

	DMS Code
___ **Level "0"** (Walks independently, normal and fluent gait)	=1
___ **Level I (**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
___ **Level II** (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
___ **Level III (**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
___ **Level IV (**Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.)	=6
___ **Level V** (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). ***For children examined after 24 months, questions 6 and 6a should be completed.***

	DMS Code
___ **Level "0"** (Walks independently, normal and fluent gait)	=1
___ **Level I** (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
___ **Level II** (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
___ **Level III** (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
___ **Level IV** (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
___ **Level V** (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. REFLEXES / MOTOR SKILLS / DIAGNOSES

1. Protective reactions (anterior, lateral and parachute) ____

1 = Symmetric 2 = Asymmetric 3 = Not present

2. Limb movements

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

a. Upper limbs ____

b. Lower limbs ____

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 (≤ 4 beats) 2 = Present (> 4 beats) 3 = Sustained

7. Plantar reflexes ____ ____

1 = Flexor plantar response	3 = Spontaneous extension ± 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 (≥ 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

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

d. Upper limb function: ____

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

	1) Right	2) Left
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	

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 CP diagnosis*** *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 (Bayley cognitive score 54) plus may have sensory impairment
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: ___ ___ ___

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, → **Normal**
If No, → **Possible Level 1**

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, → **Level 1**
If No, → **Level 2**

If No, ↓

Uses hands for sitting support; creeps on stomach or crawls, may cruise/pull to stand?
No Yes

If Yes, → **Level 2**

If No, ↓

Sits with external support for lower trunk; rolls, creeps on stomach?
No Yes

If Yes, → **Level 3**

If No, ↓

Good head control in supported sitting; can roll to supine, may roll to prone?
No Yes

If Yes, → **Level 4**

If No, ↓

Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement.

If Yes, → **Level 5**

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

Walks independently (i.e. >=10 steps), with normal and fluent gait?
No Yes

If Yes, → **Normal** (Level 0)

If No, ↓

Moves in and out of sitting and floor sit with both hands free to manipulate objects?
No Yes

If Yes, → Crawls on hands & knees, pulls to stand, takes steps holding onto furniture. Walks independently with hands free (even if has some gait abnormalities)?
No Yes

If Yes, → **Level 1**
If No, → **Level 2**

If No, ↓

Maintains floor sitting* but needs to use one or both hands for support to maintain balance?
No Yes

If Yes, → Creeps on stomach or crawls on hands and knees with reciprocal leg movement. Pulls to stand and takes steps holding onto furniture.
No Yes

If Yes, → **Level 2**
If No, → **Level 3**

If No, ↓

Maintains floor sitting* when the low back is supported?
No Yes

If Yes, → Rolls and creeps forward on stomach, or crawls with or without reciprocal leg movements.
No Yes

If Yes, → **Level 3**
If No, → **Level 4**

If No, ↓

Has head control but trunk support is required for floor sitting?
No Yes

If Yes, → Can roll to supine (and may roll to prone).
No Yes

If Yes, → **Level 4**
If No, → **Level 5**

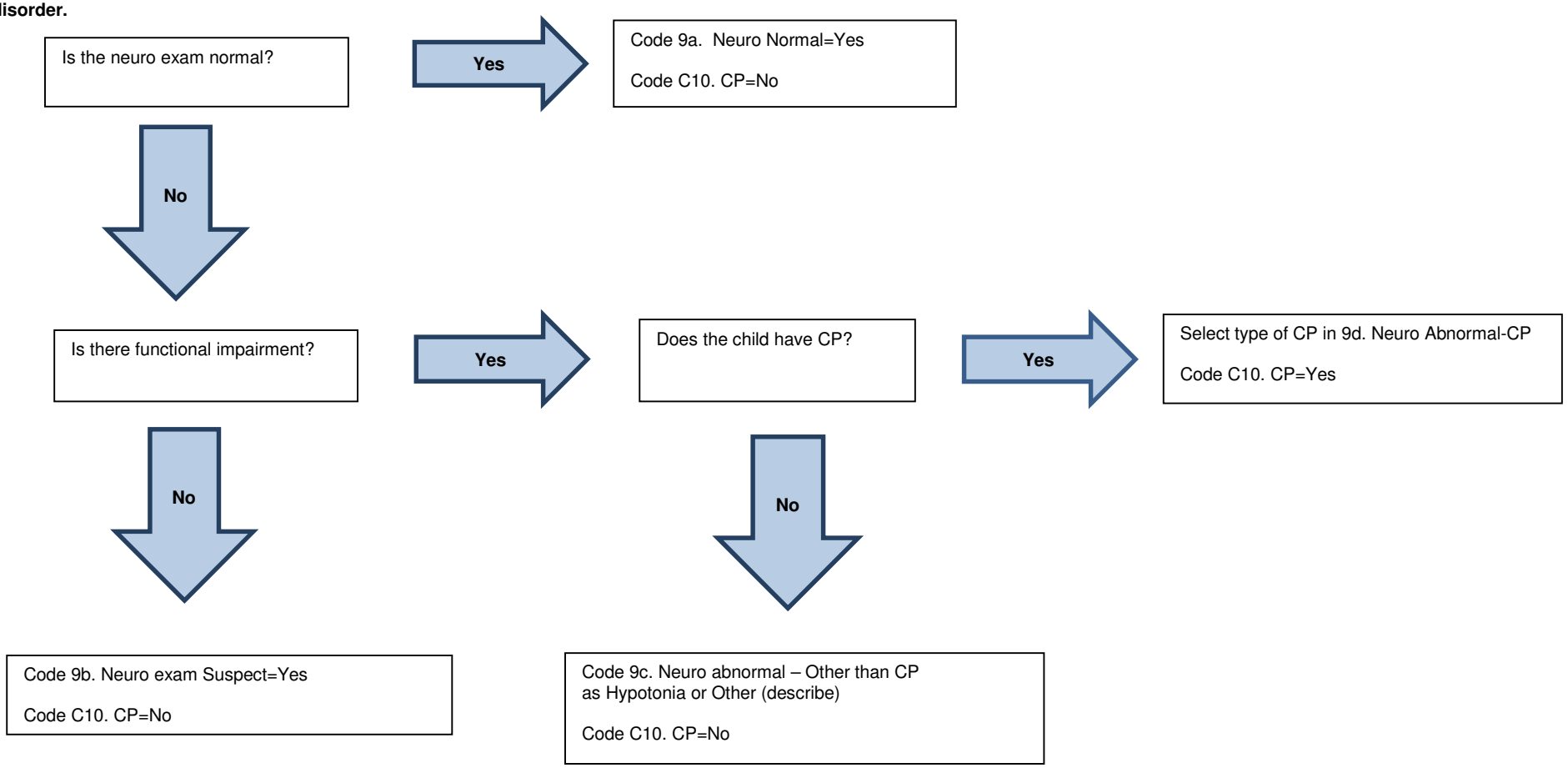
If No, ↓

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.

If Yes, → **Level 5**

*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.



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:

_____

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
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

g. Bayley Scales of Infant Development

	Raw	Scaled Score
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? Y N

1. If NO, was an interpreter required? Y N

i. Was the Bayley administrator masked to the child's medical history? Y N

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 ___ ___ ___

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

A. STATUS INFORMATION

1. Date of birth: __ __/__ __/__ __ __ __
   Month Day Year

2. Final Status of Child: ___

1=Child seen, Follow-up visit completed
3=Died after GDB status
4=Lost to follow-up
5=Follow-up visit completed at another NICU Network center
6=Child seen, but incomplete visit

IF FOLLOW-UP VISIT IS COMPLETED AS MUCH AS POSSIBLE, FILL OUT FORM NF11.

a. If final status is, died after GDB status (3):

1. Date of death __ __/__ __/__ __ __ __
   Month Day Year

b. If final status is lost to follow-up (4):

1. Give reason lost to follow-up: ___

1=Adopted	4-Refused informed consent for FU
2=Out of area	5=Non compliant
3=Lost	6=Foster care

B. FORM COMPLETION

1. Date form completed: __ __/__ __/__ __ __ __
   Month Day Year

2. Center number where child was seen: ___ ___ ___

3. Initials of person completing this form: ___ ___ ___

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:

	Clinical Judgment	Source
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: ___ ___ ___

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

	Done
1. Identification Information (NF00)?	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: ___ ___ ___

A. SOURCE OF INFORMATION AND VITAL STATUS

1. Name: (First) _____

2. Is information available for this child from indirect sources (e.g., chart review)? ***(If YES, go to Question 3.)*** Y N

   If NO,

   a. Date of last contact: __ __/__ __/__ __ __ __ (Month Day Year)

   b. Date form completed: __ __/__ __/__ __ __ __ (Month Day Year)

3. Is child alive? Y N

   a. if **YES**, corrected age when last known to be alive: __ __ (months)

   b. if **NO**, date of death: __ __/__ __/__ __ __ __ (Month Day Year)

IF CHILD IS DECEASED STOP HERE (FILL IN INITIALS TO COMPLETE FORM, PAGE 3, D2).

4. Caretaker Interview: Y N

   If **YES**,

   a. Date of interview: __ __/__ __/__ __ __ __ (Month Day Year)

   b. Corrected age of child at the time of interview: __ __ (months)

5. Were any questions completed from chart review?: Y N

   If **YES**,

   a. Date of chart review: __ __/__ __/__ __ __ __ (Month Day Year)

   b. Corrected age of child at the time of data collection: __ __ (months)

B. CARETAKER QUESTIONNAIRE

This questionnaire should be administered only to a person with a significant caretaking role.

1. How would you describe (*child's name*) _____'s health? ___

   1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent

2. Is (*name*) _____ walking alone (without holding on)? Y N

   a. if **YES**, at what age did (*name*) _____ start walking independently? __ __ (months)

   b. if **NO**, is (*name*) _____ sitting alone without support? Y N

   c. If **NO**, does (*name*) have head control? Y N

3. Can (*name*) see? Y N

4. Has (*name*) had an eye exam since initial discharge? Y N

5. Does (*name*) need or wear glasses? Y N

6. Does (*name*) hear? Y N

7. Has (*name*) had a hearing exam since initial discharge? Y N

8. Does (*name*) need or wear a hearing aid(s)? Y N

   8a) Does *(name)* need or wear a cochlear implant(s)? Y N

9. What is the estimated number of words in (*name)* _____'s vocabulary? ___

10. Can (*name*) _____ combine 2 words? Y N

11. Can (*name*) _____ combine 3 words? Y N

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 _____
(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.l.1 _____
(See Pg 4 for >24 months GMFCS descriptions)

1 = Normal (Level '0')	4 = Level II	7 = Level V
	5 = Level III	
3 = Level I	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.l.1 ____
(See Pg 4 for >24 months GMFCS descriptions)

1 = Normal (Level '0')	4 = Level II	7 = Level V
	5 = Level III	
3 = Level I	6 = Level IV	

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:	Clinical Judgment	Source
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	____	____

2. Initials of person completing this form: __ __ __

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

Gross Motor Function Level (18 Months - 21 Months 29 Days)

	DMS Code
___ **Normal** (Walks 10 steps independently and fluently)	=1
___ **Possible Level I** (Walks 10 steps independently but not fluently; child exhibits toe walking or asymmetric walking)	=2
___ **Level I** (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
___ **Level II** (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
___ **Level III** (Maintains floor sitting when the low back is supported. Rolls and creeps forward on stomach)	=5
___ **Level IV** (Has head control but trunk support is required for floor sitting. Can roll to supine and may roll to prone)	=6
___ **Level V** (Unable to maintain anti-gravity head and trunk postures in prone or sitting; little or no voluntary movement)	=7

OR

Gross Motor Function Level (22-26 Months)

	DMS Code
___ **Level "0"** (Walks independently, normal and fluent gait)	=1
___ **Level I (**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
___ **Level II** (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
___ **Level III (**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
___ **Level IV (**Infants have head control but trunk support is required for floor sitting. Infants can roll to supine and may roll to prone.)	=6
___ **Level V** (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

â If > 24 Months also answer

Gross Motor Function Level (>24 Months). ***For children > 24 months, questions B.12.l.1 and/or C.4.l.***1 ***should also be completed.***

	DMS Code
___ **Level "0"** (Walks independently, normal and fluent gait)	=1
___ **Level I** (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
___ **Level II** (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
___ **Level III** (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
___ **Level IV** (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
___ **Level V** (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

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

1. Date CBCL administered: __ __ / __ __ /__ __ __ __ Month Day Year	**4. How was CBCL administered?** ____ 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
2. Relationship of respondent to child: __ __ __ (See Relationship Codes—if biological mother, code is 001)	**5. Language CBCL was administered?** ____ 1= English 2=Spanish 3=Other, specify_____
3. Child's sex: M F	**6. Initials of person completing Summary Score Sheet:** __ __ __

B. Syndrome Scale Scores

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

C. Internalizing, Externalizing, and Total Problems

	a. Internalizing Problems	b. Externalizing Problems	c. Total Problems
1. Total Score	__ __	__ __	__ __ __
2. T Score	__ __ __	__ __ __	__ __ __
3. Percentile*	__ __	__ __	__ __

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

D. DSM-Oriented Scales

	a. Depressive Problems	b. Anxiety Problems	c. Autism Spectrum Problems	d. Attention Deficit/ Hyperactivity Problems	e. Oppositional Defiant Problems
1. Total Score	__ __	__ __	__ __	__ __	__ __
2. T Score	__ __ __	__ __ __	__ __ __	__ __ __	__ __ __
3. Percentile*	__ __	__ __	__ __	__ __	__ __

This form should be completed when requesting additional funding for extensive travel for prospective Follow-up visits for TRIAL infants only.

A. PROSPECTIVE VISIT INFORMATION *This information will be used by the extensive travel committee to make a decision on whether additional funds will be provided.*

1. Date of request: ___ ___ /___ ___ /___ ___ ___ ___
   Month Day Year

2. Was the infant was enrolled in an NRN trial: Y N
   If NO, stop here – not eligible for extensive travel funds.
   a. If YES, specify trial(s): ___, ___, ___

1=Darbe	2=EOS II	3=Hydrocortisone for BPD
4=Inositol	5=MILK	6=NEC Lap vs Drain
7=NEST	8=Preemie Hypothermia	9=TOP
10=Other, specify:_____		

3. Who will travel? ___

1=Research team will travel to the family
2=Family will travel to the clinic
3=Both the research team and family will travel

   a. If 1 or 3, indicate members of the research team that will travel by indicating Yes or No to each of the following:
      1) Neuro examiner Y N
      2) Bayley examiner Y N
      3) Coordinator Y N

4. Estimated distance to be traveled from clinic (one way): ___ ___ ___ ___ miles

5. Indicate Yes or No to each of the following that will be needed:
   a. Airline ticket Y N
   b. Train/bus ticket Y N
   c. Taxi Y N
   d. Rental car Y N
   e. Mileage reimbursement Y N
   f. Overnight hotel stay Y N
   g. Per diem for meals Y N
   h. Additional incentive Y N
   i. Other, specify:_____ Y N

6. Anticipated date of visit: ___ ___/___ ___/___ ___ ___ ___
   Month Day Year

7. Additional comments that are not noted in questions 1-6 (optional):
   _____

8. Amount requested (not to exceed $800): $___ ___ ___

B. REQUEST DECISION *Key this section after receiving the committee's decision.*

1. Was the request approved by the committee? Y N
   a. If yes, date of preauthorization: ___ ___/___ ___/___ ___ ___ ___
      Month Day Year

2. Amount approved by the committee (not to exceed $800): $___ ___ ___

C. FORM COMPLETION

1. Initials of person completing this form: ___ ___ ___