

FORM 1 REGISTRATION FORM FOR PERSON WITH CEREBRAL PALSY (CP)



Register

Piecing together the facts on cerebral palsy

Contact details (person with CP)

First name Middle name

Surname

Male Female DOB / /

Address

Postcode

Phone Email

Type of accommodation (e.g. private residence)

Suburb & postcode at time of birth

Suburb & postcode at age 5

Contact details (person responsible)

Please complete this section if individual with CP is under 18, or older than 18 but unable to give consent.

First name Surname

Type of relationship

Address (if different to person with CP)

Postcode

Phone Email

Alternate contact details

If you can not be contacted over a prolonged period, e.g. disconnected phone, mail returned to sender (preferably maternal grandmother).

Name

Type of relationship

Phone

Health professional details (may be contacted to verify or complete data).

1. Name

Type (e.g. paediatrician, GP, occupational therapist)

Phone

Place of work

Address
Postcode

Email

2. Name

Type

Phone

Place of work

Address
Postcode

Email

Birth details of person with CP

Birth place (e.g. Hornsby Hospital, home birth, birth centre)

If home birth, Unplanned Planned State

Birth weight born at weeks gestation

Hospital of neonatal transfer (if applicable)

State of hospital

Received more than routine care? Yes - NICU No - routine care only
 Yes - special care

If Yes, total length of stay days

Was MRI completed? Yes No

Which hospital?

Was this a multiple birth? Yes No

If Yes, twins triplets 4 5 6 >6

Birth order of child with CP (e.g. 2nd)

Was there any assistance with conception? (please tick)

No
 Yes, type unknown
 Yes, if known please circle which type of assistance: fertility drugs only, ovulation stimulation only, artificial insemination, ICSI, IVF, GIFT

Other

Number of previous live births to mother

Number of previous stillbirths (> 20 weeks gestation) to mother

Number of previous miscarriages (< 20 weeks gestation) to mother

Birth parent details

Mother

First name Maiden name

Surname DOB / /

Country of birth

Educational level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

Aboriginal but not Torres Strait Islander origin
 Torres Strait Islander but not Aboriginal origin
 Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin

Father

First name

Surname DOB / /

Country of birth

Educational level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

Aboriginal but not Torres Strait Islander origin
 Torres Strait Islander but not Aboriginal origin
 Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin

Clinical details of person with CP

(If you are unsure about any question, please leave blank)

Age at which CP was first formally diagnosed years months

Type of cerebral palsy

(please tick)

	Main type at initial diagnosis	Main type at or over age 5	Secondary type at or over age 5
Spasticity			
Left hemiplegia / monoplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right hemiplegia / monoplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Triplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyskinesia			
Mainly athetosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mainly dystonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypotonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resolved by age 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Known syndrome - not CP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown syndrome - not CP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Severity of cerebral palsy

(please tick one)

(please see GMFCS sheet for further information)

	At initial diagnosis	At or over age 5
GMFCS level I	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level II	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level III	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level IV	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level V	<input type="checkbox"/>	<input type="checkbox"/>

Ability to handle objects in daily life

(please tick one)

(please see MACS sheet for further information)

	At or over age 4
MACS level I	<input type="checkbox"/>
MACS level II	<input type="checkbox"/>
MACS level III	<input type="checkbox"/>
MACS level IV	<input type="checkbox"/>
MACS level V	<input type="checkbox"/>

Were any birth defects present?

(e.g. congenital heart defect)

No Yes

If yes, please give details

Is there a known syndrome?

No Yes

If yes, please give details

Comments

If you wish to make any further comments, please do so here:

I hereby verify that the above details are correct to the best of my knowledge, being the person with CP / a parent / the person responsible (please circle appropriate response).

Signature:

Relationship:

Date:

 / /

Presence of associated impairments (please tick one for each section)

Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Resolved by age 5	<input type="checkbox"/> Unknown
Intellectual	<input type="checkbox"/> No impairment	<input type="checkbox"/> Mild
	<input type="checkbox"/> Probably no impairment	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Probably some impairment	<input type="checkbox"/> Severe
		<input type="checkbox"/> Unknown
Visual	<input type="checkbox"/> No impairment	<input type="checkbox"/> Functionally blind
	<input type="checkbox"/> Some impairment (e.g. glasses)	<input type="checkbox"/> Unknown
Strabismus	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		<input type="checkbox"/> Unknown
Hearing	<input type="checkbox"/> No impairment	<input type="checkbox"/> Bilateral deafness
	<input type="checkbox"/> Some impairment (includes conductive hearing loss)	<input type="checkbox"/> Unknown
Speech	<input type="checkbox"/> No impairment	<input type="checkbox"/> Nonverbal
	<input type="checkbox"/> Some impairment	<input type="checkbox"/> Unknown

Timing of cerebral palsy

<input type="checkbox"/> Unknown	<input type="checkbox"/> During pregnancy and up to first 28 days of life (pre & perinatal)	<input type="checkbox"/> After first 28 days of life (postnatal)
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Was there a confirmed cause of cerebral palsy?

<input type="checkbox"/> Unknown	<input type="checkbox"/> In utero cytomegalovirus	<input type="checkbox"/> Other infection (toxoplasmosis, rubella, herpes simplex virus)	<input type="checkbox"/> Other infection (please list in comments)	<input type="checkbox"/> Other (please list in comments)
<input type="checkbox"/> Head injury	<input type="checkbox"/> Motor vehicle accident	<input type="checkbox"/> Non accidental	<input type="checkbox"/> Fall	<input type="checkbox"/> Other (please describe in comments)
<input type="checkbox"/> Infection	<input type="checkbox"/> Unspecified cause	<input type="checkbox"/> Viral	<input type="checkbox"/> Bacterial	<input type="checkbox"/> Dehydration due to gastroenteritis
<input type="checkbox"/> Stroke or CVA	<input type="checkbox"/> During or following surgical procedure	<input type="checkbox"/> Spontaneous	<input type="checkbox"/> Associated with other cardiac complications	
<input type="checkbox"/> Other	<input type="checkbox"/> Post seizure	<input type="checkbox"/> Near sudden infant death syndrome (SIDS)	<input type="checkbox"/> Post immunisation	<input type="checkbox"/> Near drowning
	<input type="checkbox"/> Peri-operative hypoxia	<input type="checkbox"/> Apparent life-threatening event	<input type="checkbox"/> Other (please describe in comments)	