

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

Phone (if different to person with CP)

Address (if different to person with CP)

Postcode

Email

ALTERNATE CONTACT DETAILS

If you cannot be contacted over a prolonged period, e.g. disconnected phone, returned mail etc, we will use this person to contact you (preferably maternal grandmother).

Name

Relationship Phone

HEALTH PROFESSIONAL DETAILS (with your consent, these may be contacted to verify or complete data).

1. Name

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

Place of work

Address

Postcode

Phone Email

2. Name

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

Place of work

Address

Postcode

Phone Email

BIRTH DETAILS of person with CP

Birth place (e.g. Mater hospital, home birth)

State

Birth weight Weeks completed gestation

Was it a multiple birth? Yes No

If yes, twins triplets 4 5 6 >6

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

Hospital of neonatal transfer (if applicable)

State of hospital

Admission to Neonatal Intensive Care Unit? Yes No Unknown

If Yes, length of stay days

Was MRI completed? Yes No Unknown

Which hospital?

Was there any assistance with conception (please tick)

No IVF Ovulation Stimulation Only

Yes ICSI Yes, Other

Unknown GIFT Yes, Unknown

AI

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

Occupation at time of birth

Indigenous status (please tick one)

Aboriginal only

Torres Strait Islander only

Both Aboriginal & Torres Strait Islander

Neither Aboriginal nor Torres Strait Islander

Father

First name

Surname DOB / /

Country of birth

Occupation at time of birth

Indigenous status (please tick one)

Aboriginal only

Torres Strait Islander only

Both Aboriginal & Torres Strait Islander

Neither Aboriginal nor Torres Strait Islander

CLINICAL DETAILS of person with CP

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

Age at which CP was first formally diagnosed years months

Main type of cerebral palsy

(please tick)

At initial diagnosis When over age 5

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

Severity of cerebral palsy

(please tick one)
(please see GMFCS sheet for further information)

At initial diagnosis When over age 5

GMFCS level 1	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level 2	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level 3	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level 4	<input type="checkbox"/>	<input type="checkbox"/>
GMFCS level 5	<input type="checkbox"/>	<input type="checkbox"/>

Ability to handle objects in daily life

(please tick one if applicable)
(please see MACS sheet for further information)

When over age 4

MACS level 1	<input type="checkbox"/>
MACS level 2	<input type="checkbox"/>
MACS level 3	<input type="checkbox"/>
MACS level 4	<input type="checkbox"/>
MACS level 5	<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

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 to person with CP
(e.g. Mother, legal guardian):

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	<input type="checkbox"/> Unknown
Visual	<input type="checkbox"/> No impairment	<input type="checkbox"/> Functionally blind
	<input type="checkbox"/> Some impairment (wears glasses)	<input type="checkbox"/> Strabismus only (surgically corrected or not)
	<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 and Cause 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 28 days of life (postnatal)
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Was there a definite (confirmed) cause of cerebral palsy? (Please tick one)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> In utero cytomegalovirus	Head injury
<input type="checkbox"/> Genetic chromosomal cause	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Other	<input type="checkbox"/> Non accidental
	<input type="checkbox"/> Fall
	<input type="checkbox"/> Other

Infection

<input type="checkbox"/> Unspecified cause
<input type="checkbox"/> Viral
<input type="checkbox"/> Bacterial

Cerebrovascular

<input type="checkbox"/> During or following surgical procedure
<input type="checkbox"/> Spontaneous

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"/> Other postnatal cause not specified above