Registration for Person with Cerebral Palsy (CP)

Queensland Cerebral Palsy Register, Reply Paid PO Box 386, Fortitude Valley QLD 4006

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

Received more than routine care? Yes ☐ No ☐

If yes, Number of days spent in NICU

Number of days spent in Special Care

Was MRI completed? Yes ☐ No ☐ Unknown ☐

Which hospital?

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

Education level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

- ☐ 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

Education level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

- ☐ Aboriginal only
- ☐ Torres Strait Islander only
- ☐ Both Aboriginal & Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander

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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	At or over age 5
Spasticity		
Left hemiplegia / monoplegia	☐	☐
Right hemiplegia / monoplegia	☐	☐
Diplegia	☐	☐
Triplegia	☐	☐
Quadriplegia	☐	☐
Dyskinesia		
Mainly athetosis	☐	☐
Mainly dystonia	☐	☐
Ataxia	☐	☐
Hypotonia	☐	☐
Resolved by age 5	☐	☐
Known syndrome - not CP	☐	☐
Unknown syndrome - not CP	☐	☐
Unknown	☐	☐

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	☐	☐
GMFCS level II	☐	☐
GMFCS level III	☐	☐
GMFCS level IV	☐	☐
GMFCS level V	☐	☐

Ability to handle objects in daily life

(please tick one if applicable) (please see MACS sheet for further information)	At or over age 4
MACS level I	☐
MACS level II	☐
MACS level III	☐
MACS level IV	☐
MACS level V	☐

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

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

Epilepsy
☐ Yes ☐ No ☐ Resolved by age 5 ☐ Unknown

Intellectual
☐ No impairment ☐ Mild ☐ Probably no impairment ☐ Moderate ☐ Probably some impairment ☐ Severe ☐ Unknown

Visual
☐ No impairment ☐ Functionally blind ☐ Some impairment (wears glasses) ☐ Unknown
Strabismus ☐ No ☐ Yes ☐ Unknown

Hearing
☐ No impairment ☐ Bilateral deafness ☐ Some impairment (includes conductive hearing loss) ☐ Unknown

Speech
☐ No impairment ☐ Nonverbal ☐ Some impairment ☐ Unknown

Timing of cerebral palsy

☐ Unknown ☐ During pregnancy and up to first 28 days of life (pre & perinatal) ☐ After 28 days of life (postnatal)

Was there a confirmed cause of cerebral palsy?

☐ Unknown
☐ In utero cytomegalovirus
☐ Other infection (toxoplasmosis, rubella, herpes simplex virus)
☐ Other (please list in comments)

Head injury
☐ Motor vehicle accident
☐ Non accidental
☐ Fall
☐ Other (please describe in comments)

Infection
☐ Unspecified cause
☐ Viral
☐ Bacterial
☐ Dehydration due to gastroenteritis

Stroke or CVA
☐ During or following surgical procedure
☐ Spontaneous
☐ Associated with other cardiac complications

Other
☐ Post seizure
☐ Near sudden infant death syndrome (SIDS)
☐ Post immunisation
☐ Near drowning
☐ Peri-operative hypoxia
☐ Apparent life-threatening event
☐ Other (please describe in 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 to person with CP (e.g. Mother, legal guardian): Date: / /