HOSPITAL BASED SURVEILLANCE OF CP IN HANOI, Vietnam

FOR PERSON WITH CEREBRAL PALSY (CP)

Contact details (person with CP)

First name ____ Middle Name ____ Surname ____

Gender: ☐ Male ☐ Female DOB (DD/MM/YYYY) __ __ /__ __ /__ __ __ __

Ethnic Group: ☐ Vietnamese ☐ Tay ☐ Thai ☐ Chinese ☐ Khmer ☐ Muong ☐ Nung ☐ Hre ☐ Phu ☐ E de ☐ Dao ☐ Co tu ☐ Cham ☐ Other, please specify...

Address

House No: Street name:

Sub-district: District: Province:

Postcode: Email: Telephone/Mobile No:

Demographics and primary health indicators (person/family of person with CP)

Type of accommodation flooring: ☐ Finished floor ☐ Rough wood/bamboo ☐ Earth, sand

Number of household member: .... Persons; Number of rooms in the household: .... Rooms

Source of Drinking Water: ☐ Piped water ☐ Well water ☐ Other sources (ponds, river, stream, lake)

Sanitation: ☐ Flush toilet ☐ Pit toilet ☐ No facility, bush

Monthly family income of the child with CP (in Vietnamese Dong) .... Dong

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

House No: Street name:

Sub-district: District:

Province: Postcode: Email:

Telephone/Mobile No:

Health Professionals details

Name ____

Type (e.g. Medical practitioner, Physiotherapist, Occupational therapist) ____

Phone/Mobile ____ Place of work ____

Address ____

Email ____

Birth details of person with CP and maternal pregnancy details

Birth place ☐ Hospital ☐ Health Care Centre ☐ birth centre ☐ home birth ☐ Other/Specify...........................

If home birth, ☐ Unplanned ☐ Planned, Delivery attended by ☐ Skilled birth attendant/TBA ☐ Other family members ☐ Doctor/Midwife

Birth weight (in gram) [ ] or ☐ Unknown Born at [ ] weeks gestation

Was there any sign of birth asphyxia (e.g. very weak breathing/cry, cyanosis, bradycardia, poor muscle tone/reflexes, meconium strained liquor, seizure - circle which applies): ☐ No ☐ Yes ☐ Don't Know

Did the child show any early feeding difficulties (first month of life) manifesting as poor sucking abilities?
☐ No ☐ Yes ☐ Don't Know

Mode of delivery ☐ Spontaneous vaginal delivery ☐ Instrumental delivery ☐ Caesarean section

Any complications during child birth/labour ☐ No ☐ Yes

If yes specify (please tick) ☐ Obstructed/prolonged labour (active phase of labour >12 hours) ☐ Malpresentation
☐ Pre-eclampsia/Eclampsia ☐ Haemorrhage ☐ Premature rupture of membranes/premature labour (<37 weeks) ☐ Other complications,

If other please specify [ ]

Did the mother experience any febrile illness during pregnancy ☐ No ☐ Yes ☐ Don't Know

If yes, was it associated with rash? ☐ No ☐ Yes ☐ Don't Know
If yes, please specify when did the rash appear? ☐ 1-12 weeks ☐ 13-28 weeks ☐ 29-40 weeks ☐ Don't Know

Did the mother experience any febrile illness during labour/child birth? ☐ No ☐ Yes ☐ Don't Know

Did the mother receive any antenatal care during pregnancy? ☐ Yes ☐ No

If Yes, ☐ Regular ☐ Irregular (but >2 visits) ☐ Irregular (<2 visits)

Did the mother receive any nutritional supplementation during pregnancy (e.g. Iron/Folic acid) ☐ Yes ☐ No ☐ Don't Know

[If multiple hospital transfer, specify highest level]
Hospital of neonatal transfer (if applicable) [ ] District of hospital [ ]

Received more than routine care? ☐ Yes – NICU [e.g. intubation & ventilation] ☐ Yes - special care [e.g. Phototherapy, NG feeding] ☐ No - routine care only [e.g. Observation]

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 in the family (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 ______ Middle Name ______ Surname ______

DOB (DD/MM/YYYY) __ __ /__ __ /__ __ __ __ Mother's educational level at time of child's birth: ☐ Illiterate

☐ Primary ☐ Secondary ☐ Higher secondary ☐ Graduation ☐ Post graduation ☐ Diploma/other trade qualification

Mothers occupation at time of child's birth ______

Father

First name ______ Middle Name ______ Surname ______

DOB (DD/MM/YYYY) __ __ /__ __ /__ __ __ __ Father's eeducational level at time of child's birth: ☐ Illiterate

☐ Primary ☐ Secondary ☐ Higher secondary ☐ Graduation ☐ Post graduation ☐ Diploma/other trade qualification

Father's occupation at time of child's birth ______

Are the parents related (blood related, i.e. first cousin) ☐ Yes ☐ No

Is there any other family member with disability? ☐ Yes ☐ No

If yes, how the other disabled family members related to the child with CP? ☐ Sibling ☐ Parent ☐ Both

Please specify the disability/impairment of the other family member (s) ______

Clinical details of child 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 (<5 years)**	**Main type at or over age 5**	**Secondary type 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)	**Main type at initial diagnosis**	**at or over age 5**
GMFCS level I	☐	☐
GMFCS level II	☐	☐
GMFCS level III	☐	☐
GMFCS level IV	☐	☐
GMFCS level V	☐	☐

Comment (e.g. any difficulty in assessing the GMFCS level)

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	☐
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 ☐ Resolved by age 5	☐ No ☐ Unknown
Intellectual	☐ No impairment ☐ Probably no impairment ☐ Probably some impairment	☐ Mild ☐ Moderate ☐ Severe ☐ Unknown
Visual	☐ Some impairment (e.g. glasses) ☐ No impairment **Strabismus ☐ No ☐ Yes**	☐ Functionally blind ☐ Unknown **☐ Unknown**
Hearing	☐ No Impairment ☐ Some impairment (includes conductive hearing loss)	☐ Bilateral deafness ☐ Unknown
Speech	☐ No impairment ☐ Some impairment	☐ Non verbal ☐ Unknown

Timing of cerebral palsy? ☐ **Unknown** ☐ **During pregnancy and up to first 28 days of life (pre & perinatal)** ☐ **After first 28 days of life (postnatal)**

Was there a confirmed cause of cerebral palsy?

During pregnancy and up to first 28 days of life (pre & perinatal):

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

After first 28 days of life (postnatal):

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)

Comments

Immunisation history

Is the child fully immunised? ☐ Yes ☐ No ☐ Don't know

1. BCG and HepB vaccine after Birth ☐ 2. DPT-HepB-Hib and OPV at 2 months ☐ 4 months ☐ and 6 months ☐
3. Measles vaccine 9 months ☐ 4. Measles and Rubella vaccine 18 months ☐ 5. Japanese encephalitis vaccine 12 months ☐; + 2 weeks ☐; 2 years ☐

If No, reason why the child missed immunisation?
☐ Not aware ☐ No money ☐ Transport problem ☐ Others, please specify

Is there any BCG vaccine mark? ☐ Yes ☐ No

If the child is 9 months to 15 years old, did the child receive Measles-Rubella (MR) vaccine on 2015 National MR campaign [☐ N/A] ☐ Yes ☐ No

Nutrition

Current weight of the child ______ in Kg

Mid arm circumference of the child ______ in cm **Head circumference** of the child ______ in cm

Height of the child ______ in cm [knee height in cm ....]

(those with deformities, estimate height using the knee height equation, Height = (2.69 x knee height) + 24.2)

Education

Is the Child Currently attending mainstream school? ☐ Yes ☐ No ☐ Not applicable

Type of School if the child is attending a school ☐ Primary ☐ secondary ☐ Vocational/Other

Is the child currently attending any special school? ☐ Yes ☐ No

If not attending any school (6+ years) reason why? ☐ Working ☐ School too far ☐ Disability not accepted by school ☐ Lack of money

☐ Parents refused ☐ Other reason, specify ______

Rehabilitation

Has the child ever received any rehabilitation service or other related support ☐ Yes ☐ No

What type of support was received?

☐ **Assistive/adaptive device** ☐ Surgery ☐ Therapy exercises ☐ Advice ☐ Other, Specify ______

If Assistive/adaptive device is ticked, please specify which applies;

☐ Wheelchairs ☐ Standing/walking aids (walker/frame) ☐ Strollers ☐ Orthotics (AFO/KFO) ☐ Specialised seating (corner chair) ☐ Mealtime Aids ☐ Communication Aids, Other ☐, Please specify...

What was the type of location for accessing these rehabilitation services?

☐ Home based ☐ NGO centre ☐ Hospital ☐ Private clinic

Age at when the child first received any rehabilitative services ______ (in years)

Reason why child NEVER received rehabilitation?

☐ Not aware ☐ No money ☐ Transport problem ☐ Others, please specify ______

General health

Number of hospitalizations for chest infections/respiratory infections in the past 6 months: .... times

Does the child have any swallowing difficulty? ☐ Yes ☐ No ☐ Unknown

Does the child have reflux (gastro-oesophageal reflux disease – GORD)? ☐ Yes ☐ No ☐ Unknown

The above information has been collected by ______ on __ __ /__ __ /__ __ __ __

who is a (please tick) ☐ Medical practitioner ☐ Physiotherapist ☐ Occupational therapist ☐ Speech pathologist