



[YOUR ADDRESS HERE]

[DATE]

Dear Dr

RE: Long Term Neurodevelopmental Follow Up  
Baby Name NHS No:

The above baby whose mother was originally booked for delivery at your Trust received some neonatal care on our unit in the Staffordshire, Shropshire and Black Country Newborn Network. The Newborn Network has a programme of following up babies born prematurely at less than 31 weeks gestation and/or those with a very low birth weight, of less than 1250g, in order to assess how babies of different gestations and those with specific neonatal issues develop as they get older. The network carries out a Bayley III developmental assessment at a corrected age of 2 years – 2 years 3 months.

Please find enclosed a copy of the proforma we use to collect the data from the assessment. In order to assess the development of the above child who falls within the network criteria for assessment we would be grateful if you would complete as much of the enclosed proforma as possible and/or send copies of discharge and follow up clinic letters to myself at the above address. If you are planning to undertake an assessment at 2 years we would be grateful for the results.

If you are not the responsible consultant for follow up of this child please can you forward it to the correct person. Your assistance is greatly appreciated. Should you have any queries please do not hesitate to contact me.

Yours sincerely



## DEVELOPMENTAL FOLLOW UP

### At Two Years Corrected Age

**NHS Number**

<b>NAME:</b>	<b>Gender:</b>
<b>Date of Birth:</b>	<b>Child's Unit No:</b>
<b>Corrected Age 2 on:</b>	<b>Mother's Unit No:</b>

Form completed by \_\_\_\_\_ at (hospital name) \_\_\_\_\_

If child has Died please give Date of Death \_\_\_/\_\_\_/\_\_\_ Cause \_\_\_\_\_

Date of last out patient assessment \_\_\_/\_\_\_/\_\_\_ Corrected Age of Child \_\_\_ months

Is child currently being Followed Up Yes / No

If child has been Discharged please give Date of discharge \_\_\_/\_\_\_/\_\_\_

Reason for discharge (e.g. Normal no obvious reason for review, Discharged to community paediatrician.)

\_\_\_\_\_

If child is being followed up elsewhere please state

Followed up by (name) \_\_\_\_\_ at (location) \_\_\_\_\_

If child has failed to attend please state

First Date Did Not Attend \_\_\_/\_\_\_/\_\_\_ No of times D N A \_\_\_\_\_

**Child Lives With (Please circle)**                      Parent(s)                      Foster parents                      Adoptive parent

**Anthropometry**

Weight .....kg                                      Length (supine) .....cm

**Hospital Admissions** since discharge from maternity services

Date of admission	No of Days in Hospital	Reason for admission

**Neurodevelopmental status** (Circle one in each section - add requested data if available)

- Walking**
- Normal gait
  - Non-fluent gait
  - Abnormal gait; reduced mobility
  - Unable to walk without assistance
  - Cannot walk even with assistance
- Sitting**
- Sits normally
  - Sits unsupported but unstable
  - Sits only if supported
  - Unable to sit at all
- Feeding with hands**
- Normal hand use
  - Some difficulty feeding; one hand
  - Some difficulty feeding; both hands
  - Unable to feed self
- Head control**
- Normal head control
  - Unstable but no support needed
  - Unable to control head without support
- Seizures**
- None
  - No treatment required
  - No seizures on treatment
  - Less than 1 seizure/month on treatment
  - More than 1 seizure / month on treatment
- Vision**
- Normal vision
  - Normal vision with correction
  - Not fully correctable defect
  - Blind or sees light only in both eyes
  - Blind or sees light only in one eye
- Squint**
- No
  - Yes
- Hearing**
- Normal
  - Impaired                      R.....decibels    L.....decibels
  - Hearing aids

**Language**

**Comprehension**

- Normal
- Unable to comprehend word out of familiar context
- Unable to comprehend word in cued situation (e.g. give me the 'toy': toy in vision)

**Expression**

- Two word sentences - many single words
- Single words only and vocabulary > 10 words
- Vocabulary < 10 words
- Unable to produce > 5 recognisable sounds
- No vocalisation

**General health status**

**Gastrointestinal / feeding problems**

- None
- Special diet
- Gastrostomy
- Tube feeding
- Parenteral nutrition
- Stoma
- Other Describe .....

**Respiratory problems**

- Describe .....(e.g. Asthma Aspiration Pneumonia)
- None
- Yes - no drugs
- Yes - on drugs
- Oxygen therapy > 1 hour/day
- Tracheostomy

**Renal impairment**

- None
- Yes - no treatment
- Yes - treated with drugs or diet
- Yes - treated with dialysis

**Therapeutic Support Services (Please circle all that apply)**

Physiotherapy	Referred	Currently receiving care	Has received care
Occupational Therapy	Referred	Currently receiving care	Has received care
Speech Therapy	Referred	Currently receiving care	Has received care
Special Education Service - Seris/Portage	Referred	Currently receiving care	Has received care
Psychology	Referred	Currently receiving care	Has received care
Other e.g. Peripatetic teaches	Referred	Currently receiving care	Has received care

Describe .....

**Developmental Status** (Circle one or more relevant sections - add requested data if available)

Is the child's development in the normal range      Yes                  No

If a standardised assessment is available please record results

Test name \_\_\_\_\_

Chronological age at testing \_\_\_\_\_      Developmental age \_\_\_\_\_ mo

Is the child on a disability register?                          No    Yes

Does the child attend a special unit nursery group?      No    Yes

Is the child likely to have special educational needs?      No    Yes

List any congenital malformation or disorders.....

.....

**Conditions Associated with Disability**

**Cerebral Palsy**      No      Yes

**Type**    Diplegic    Quadriplegic    Hemiplegic    Dystonic    Hypotonic    Mixed    Other

**Any concurrent neurological problems** (e.g. hydrocephalus ± shunt)

.....

**Vision**    Cause of loss .....

**Hearing**    Type of loss .....Cause .....

**Any other disability**

Disability .....Cause .....

Disability .....Cause .....

**Thank you for your help (please return the completed form in the envelope provided)**