

**Queensland Early Detection and Intervention Network – Cerebral Palsy (QEDIN-CP):
For clinical screening of infants at risk of CP and potential referral to early intervention clinical trials**

Child and Family Details

Child's Name:			
DOB:	EDD:	GA at birth:	Gender: M/F
Parent(s) Name:			
Parent(s) Address:			
Parent(s) Email:			
Parent(s) Phone Number:			
Hospital and Record Number (if known):			

Referrer Details

Name of referrer:	Date of referral:
Profession:	
Organisation:	
Address:	
Phone Number:	Email Address:
Any other clinicians to be included in correspondence regarding this child (Name, Profession, Email):	
Has the child's parent(s) given permission for their contact details to be passed onto QEDIN-CP?	Yes/No
Has the child's parent(s) been given a flyer relating to QEDIN-CP?	Yes/No

Medical History / Reason for referral

Cranial Ultrasound (CUS) Date:	PMA at CUS:	Location of CUS:
CUS report/results:		
Brain MRI Date:	PMA at MRI:	Location of MRI:
Brain MRI report/results:		
Have the family been given any formal diagnoses? (I.e. CP, "Interim diagnosis of high risk of CP", other)		
Is/are the parent(s) concerned about the child's development (circle)?		Yes/no

Clinical assessments results if already completed locally:

General Movements Assessment (GMs)		
Writhing assessment (birth to +/-9 weeks post term age): CA at assessment:		Score:
Fidgety assessment (9-20weeks PMA): CA at assessment:		Score:
Hammersmith Infant Neurological Examination (HINE)		
CA at assessment:	Number of asymmetries:	Score:
Other Assessments completed:		
Assessment:	Date:	Score:
Assessment:	Date:	Score:

The following will help QEDIN-CP to determine eligibility for early intervention studies:

Has the infant been discharged home from hospital?	yes	no	unsure
Is English spoken in the home?	yes	no	unsure
Can the infant visually fix and follow in good light through 180 degrees? (using a bright object, at arm's length, from 3 months corrected age)	yes	no	unsure
Does the infant have severe visual impairment (visual acuity below 1 cycle/degree)?	yes	no	unsure
Does the infant have an anatomical malformation preventing any vision? E.g. Bilateral anophthalmia or microphthalmia? Comment:	yes	no	unsure
Does the infant have drug resistant epilepsy meeting International League against Epilepsy (ILEA) criteria?	yes	no	unsure
Is the infant medically fragile preventing the ability to participate in safe age appropriate activities? Comment:	yes	no	unsure
Is the child involved in any other research studies that you are aware of (e.g. SUPREME, PAEAN, PREBO)? Study name: Study ID if known:	yes	no	unsure
Does one or both of the child's parents identify as Aboriginal and/or Torres Strait Islander?	yes	no	unsure

Any specific requests for the QEDIN team? (i.e. please complete GMs/ HINE/ family would like to use Baby Moves app etc):

1. If You are requesting QEDIN to obtain GMs videos using the Baby Moves app, **please indicate:**

QEDIN to score GMs
 Please send GMs videos back to referring team to score

2. If there are any studies you would like to specify that might be suitable, please tick or cross as appropriate:

REACH GAME VISIBLE Early PACT LEAP-CP (Indigenous) KITE CP

QEDIN will return any assessment results to the referrer/treating clinician.

Regarding the feedback of results to the family (please select one option below):

I/referrer will feed back results to the family
 I request that QEDIN feed back the results to the family
 Other, please specify: _____

Clinician signature:

Date:

Parent(s) Signature:

Date:

Based on this referral the family will be contacted by QEDIN-CP to seek informed consent for screening and/or to be given information about early intervention studies their child may be eligible for.

Please send the completed referral to the QEDIN team: qedincp@uq.edu.au; qedin.cp@health.qld.gov.au

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