leeds children's hospital

The Leeds Teaching Hospitals NHS
NHS Trust

# Selective Dorsal Rhizotomy Pre-Clinic Information Form

**Leeds MDT Spasticity Service**

**Patient**: ............................................................................. **Date of birth**: ........./......... /...............(dd/mm/yyyy)

**Parents/guardians**: ...........................................................................................................................................

**Address**: ..........................................................................................................................................................

**City**: .......................................................... **County**: ......................................... **Postcode**: ....................................

**Home Phone**: ......................................... **Mobile**: ........................................ **Fax**: ..........................................

**E-Mail Address**:...........................................................................................................................................

**Sex**: Male / Female **Height**: ...................... (cm) **Weight**: ...................... (kg)

## MEDICAL HISTORY

### Pregnancy

**Duration**: .................... weeks **Birth Weight**: ...............kg ...............gm

**Problems in Pregnancy**?: .........................................................................................................

**Delivery:** **Normal vaginal delivery**: Yes / No **Forceps** Yes / No **Caesarean section**: Yes / No

Other ..................................................................................................................................

### Neonatal problems

Was your child admitted to a **Neonatal Unit**? Yes / No

**Ventilator**: Yes / No If yes, how long? ..........................

**Was your child discharged home on oxygen & for how long**? ...............................................

**Brain haemorrhage**: Yes / No If yes, what grade? .......................

**Hydrocephalus**: Yes / No

**Was shunt placed**? Yes / No When? ....................................................

**Shunt revisions?** Yes / No Dates: .......................................................

**Epilepsy / Seizures**: Yes / No

**Feeding problems**: Were there any feeding problems at discharge? Yes / No

## Cerebral Palsy

**Age cerebral palsy diagnosed**: ………………………….

**Why was the diagnosis made?** (eg delayed milestones) ……………………………………………………………………….

**Type of cerebral palsy**: Spastic diplegia / Quadriplegia / Triplegia / Hemiplegia *(delete as applicable)*

**CT brain scan**: Yes / No Date: …………………..

**MRI Brain scan**: Yes / No Date: …………………..

**Oral Baclofen**: Currently / Tried in past / Never tried

**Baclofen Dose** *(if applicable)* ……………………………………………………………………………………………………

**Any other Medicines** (eg pain-relief, seizure medication, meds for constipation / reflux / asthma etc)

Please list names of medications: …………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………………………………….

**Any medication allergies?** Yes / No Please list: …………………………………………………………………………………….

**Botulinum Toxin Therapy?**

**Has your child had Botulinum Toxin therapy** Yes / No

**When did they have this?** (approx. dates) …………………………………………………………………………………..

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**What difference did it make?** (eg change in pain / stiffness / ease of movement / sleep)

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## Physiotherapy

**Is your child currently receiving physiotherapy**? Yes / No How Many times / week? …………..

**What is your child working on in therapy at present**?

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……………………………………………………………………………………………………………………………………………

**Does your child participate in other therapeutic type activities?** *(ie swimming/horseriding)*:

**Please Detail** ……………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

**Does your child use any of the equipment listed below?**

*Please detail the equipment type / brand, when it is used and how it is tolerated*

Walking aid …………………………………………………………………………………………………………………………

Orthotics(splints) ……………………………………………………………………………………………………………

Night splints or positioning in bed ………………………………………………………………………………

Specialist seating ……………………………………………………………………………………………………………

Wheelchair ……………………………………………………………………………………………………………………………

Standing frame ………………………………………………………………………………………………………………….

## Orthopaedic Surgery – **Has your child had any muscle / bone surgery?** Yes / No

Please list (& include removal of metalwork too): …………………………………………………………………

……………………………………………………………………………………………………………………………………………

**Any Other operations** ……………………………………………………………………………………………………….

**When was your child's last Hip x-ray?**

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**Does your child have any problems with their spine (eg scoliosis) or posture?**

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## General Development

**Speech** Age appropriate? Yes / No

**Learning** Age appropriate? Yes / No

**Hearing Normal?** Yes / No

**Vision Normal**? Yes / No

**Does your child attend:** mainstream school / nursery **or** specialist school or nursery**?**

**Do they have an educational health care plan / statement of special educational needs?** Yes / No

**Is your child's hand control / dexterity normal for age?** Yes / No

**Are there any things that your child used to be able to do that they cannot do now?**

**If Yes, please detail:** (eg loss of hand function) ……………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………….

**Does your child have any problems with bladder / bowel control?** Yes / No

**If Yes, please detail:** (eg constipation / still in nappies) ……………………………………………………………………..

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## Developmental History

***At what age did the child first:***

| | | | |
|---|---|---|---|
| Sit alone on the floor | ……………………….. | Sit alone on bench | ……………………….. |
| Crawl on hands and knees | ……………………….. | Get into sitting | ……………………….. |
| Pull to stand up | ……………………….. | Stand alone | ……………………….. |
| Walk with assistive device | ……………………….. | Walk alone | ……………………….. |

***<u>Please also complete the GMFCS assessment at end of this questionnaire</u>***

## Please indicate if your child has been diagnosed with any of the following illnesses.

| | | |
|---|---|---|
| **Does your child have epilepsy? & how often are fits?** | | Yes / No |
| **Problems with Anaesthetic** | | Yes / No |
| **Heart Problems** | Congenital Heart Defect | Yes / No |
| | Heart Murmur | Yes / No |
| **Lung Problems** | Asthma/Wheezing | Yes / No |
| | Pneumonia | Yes / No |
| | Broncho Pulmonary Dysplasia (BPD) | Yes / No |
| **Hormone Problems** | Thyroid | Yes / No |
| | Diabetes | Yes / No |
| | Growth Delay | Yes / No |
| **Gastrointestinal Problems** | Reflux | Yes / No |
| | Do they have gastrostomy? | Yes / No |
| **Kidney / Bladder Problems** | Renal Dysfunction | Yes / No |
| | Kidney Infections | Yes / No |
| | Urinary Tract Infections | Yes / No |
| **Blood Problems** | Bleeding Problems | Yes / No |
| | Anaemia | Yes / No |
| **Other** | ADD/ADHD | Yes / No |
| | Learning Disability | Yes / No |

***Please comment on any "Yes" answers***: ……………………………………………………………………………………………………….

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## How does muscle stiffness / spasticity interfere with your child's life?

**Problems with Physical activity?** (eg standing, stepping, sitting) ………………………………………………….

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**Problems with Pain?** ……………………………………………………………………………………………………………

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**Problems with Sleep?** ………………………………………………………………………………………………………….

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## What are your child's Hobbies / interests? What activities do they enjoy?

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## What are your Goals for your child? What would you like to improve?

Please explain in your own words what improvements you hope to see in your child, how you hope that we may help you and specific questions you may have:

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## SDR Follow-up

SDR is a complex treatment and requires careful follow-up. Post-SDR appointments are made in Leeds at 6-months, 1-year, 2-years, 5-years & 10-years.

**Are you willing to keep post-operative follow-up appointments as above?** Yes / No

### General Practitioner (GP)

Name ..........................................................................................................................................

Address: ......................................................................................................................................

City: ..................................................... County: ............................................ Postcode: .......................................

Phone: .............................................. Fax: ..................................................

### Paediatrician / Neurologist

Name ..........................................................................................................................................

Address: ......................................................................................................................................

City: ..................................................... County: ............................................ Postcode: .......................................

Phone: .............................................. Fax: ..................................................

### Orthopaedic Surgeon

Name ..........................................................................................................................................

Address: ......................................................................................................................................

City: ..................................................... County: ............................................ Postcode: .......................................

Phone: .............................................. Fax: ..................................................

### Physiotherapist

Name ..........................................................................................................................................

Address: ......................................................................................................................................

City: ..................................................... County: ............................................ Postcode: .......................................

Phone: .............................................. Fax: ..................................................

### Occupational Therapist

Name ..........................................................................................................................................

Address: ......................................................................................................................................

City: ..................................................... County: ............................................ Postcode: .......................................

Phone: .............................................. Fax: ..................................................

***Please return this completed form to:***

Nicola Shackleton
SDR MDT Coordinator,
Paediatric Neurology, Room 35,
F Floor, Martin Wing,
Leeds General Infirmary,
Great George Street
Leeds, LS1 3EX
Tel 0113 392 6193
Email: nicola.shackleton@nhs.net

**If you have reports or CDs of X-rays or MRI scans, please send us copies.**
**If you don't have copies, please let us know and we can contact the hospital to request them.**
***Please phone us with the details.***

*Questionnaire adapted with kind permission from Dr Park, St Louis Children's Hospital*

# GMFCS Family Report Questionnaire:
# Children Aged 2 to 4 Years

Please read the following and mark **only one box** beside the description that best represents your child's movement abilities.

My child…

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☐ **Has difficulty controlling head and trunk posture in most positions**
and uses specially adapted seating to sit comfortably
and has to be lifted by another person to move about

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☐ **Can sit on own when placed on the floor and can move within a room**
and uses hands for support to maintain sitting balance
and usually uses adaptive equipment for sitting and standing
and moves by rolling, creeping on stomach or crawling

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☐ **Can sit on own and walk short distances with a walking aid** (such as a walker, rollator, crutches, canes, etc.)
and may need help from an adult for steering and turning when walking with an aid
and usually sits on floor in a "W-sitting" position and may need help from an adult to get into sitting
and may pull to stand and cruise short distances
and prefers to move by creeping and crawling

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☐ **Can sit on own and usually moves by walking with a walking aid**
and may have difficulty with sitting balance when using both hands to play
and can get in and out of sitting positions on own
and can pull to stand and cruise holding onto furniture
and can crawl, but prefers to move by walking

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☐ **Can sit on own and moves by walking without a walking aid**
and is able to balance in sitting when using both hands to play
and can move in and out of sitting and standing positions without help from an adult
and prefers to move by walking

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GMFCS modified with permission from Palisano et al. (1997) Dev Med Child Neurol, 39, 214-223.