

Physiotherapy Information Gathering Form – Selective Dorsal Rhizotomy Candidates

To be completed by Physiotherapist please

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

Parents/guardians:

Address:

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

Child's diagnosis: include distribution/severity of spasticity, GMFCS level, MRI results, deformities/contractures

Physiotherapist Name:

Base & Contact No.:

Email:

Current Level of Physiotherapy Input & Compliance:

Occupational Therapist's name:

Base & Contact No.:

Email:

Equipment

Mobility devices:

Orthotics:

Seating:

Standing:

What is Your opinion on suitability for SDR surgery?

Child's current functional abilities:

		Independent	Assisted	Unable to Do
Rolling	Supine to Side lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supine to Prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prone to Supine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Needs Trunk Support	3 Secs	Arms Free For: 5 Secs	Indefinite
Sitting	Cross-legged on floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Long-legged on floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	On a bench	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Independent	Assisted	Unable to Do	Can reach with one hand
Kneeling	Four-Point Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	High Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Half-Kneeling Left leg up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Half-Kneeling Right leg up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

		Independent	Assisted	Unable to Do
Crawling	Reciprocally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Commando	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Requires full support	3 Sec	Hands Free For: 5 Sec	Indefinite	Squats to pick up toys
Standing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mobility	Mainly crawls	<input type="checkbox"/>
	Cruises round furniture	<input type="checkbox"/>
	Uses assistive device indoors and outdoors	<input type="checkbox"/>
	Walks independently indoors but assistive device outdoors	<input type="checkbox"/>
	Walks independently but W/C for long distances	<input type="checkbox"/>
	No limitation to walking	<input type="checkbox"/>
	Able to run independently	<input type="checkbox"/>
	Can jump with both feet off floor	<input type="checkbox"/>

		Independent no bannister	Independent with bannister	Needs assistance	On Hands & Knees
Stairs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Independent	Assisted	Unable to Do
Transitions	Supine to sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sitting to Four-point kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Four-point to High-kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	High-kneeling to standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sitting on chair to standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature:

Grade:

Date:

Please return form to: Kate McCune, Specialist Children's Physiotherapist, Child Therapy Department, A-floor Clarendon Wing, Leeds General Infirmary, Great George St, Leeds, LS1 3EX

Email: k.mccune@nhs.net

Tel 0113 392 6361

Fax 0113 392 3720