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) ……..

……

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?

……

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

……

……

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) ……..

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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: ……..

……..

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 4 to 6 Years

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

My child…

❑ **Has difficulty sitting on their own and controlling their head and body posture in most positions**

and has difficulty achieving any voluntary control of movement
and needs a specially-adapted supportive chair to sit comfortably
and has to be lifted or hoisted by another person to move

❑ **Can sit on their own but does not stand or walk without significant support and adult supervision**

and may need extra body / trunk support to improve arm and hand function
and usually needs adult assistance to get in and out of a chair
and may achieve self-mobility using a powered wheelchair or is transported in the community

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❑ **Can walk on their own using a walking aid** (such as a walker, rollator, crutches, canes, etc.)

and can usually get in and out of a chair without adult assistance
and may use a wheelchair when travelling long distances or outside
and finds it difficult to climb stairs or walk on an uneven surface without considerable help

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❑ **Can walk on their own without using a walking aid, but has difficulty walking long distances or on uneven surfaces**

and can sit in a normal adult chair and use both hands freely
and can move from the floor to standing without adult assistance
and needs to hold the handrail when going up or down stairs
and is not yet able to run and jump

❑ **Can walk on their own without using a walking aid, including fairly long distances, outdoors and on uneven surfaces**

and can move from the floor or a chair to standing without using their hands for support
and can go up and down stairs without needing to hold the handrail
and is beginning to run and jump

Available from *CanChild* Centre for Childhood Disability Research (www.canchild.ca), McMaster University
GMFCS modified with permission from Palisano et al. (1997) Dev Med Child Neurol, 39, 214-223.