FORM 1 REGISTRATION FORM
FOR PERSON WITH CEREBRAL PALSY (CP)

CP Register
Piecing together the facts on cerebral palsy

Contact details (person with CP)

First name | Middle name

Surname

Male ☐ Female ☐ DOB / /

Address

Postcode

Phone | Email

Type of accommodation (e.g. private residence)

Suburb & postcode at time of birth

Suburb & postcode at age 5

Contact details (person responsible)

Please complete this section if individual with CP is under 18, or older than 18 but unable to give consent.

First name | Surname

Type of relationship

Address (if different to person with CP)

Postcode

Phone | Email

Alternate contact details

If you can not be contacted over a prolonged period, e.g. disconnected phone, mail returned to sender (preferably maternal grandmother).

Name

Type of relationship

Phone

Health professional details (may be contacted to verify or complete data).

1. Name

Type (e.g. paediatrician, GP, occupational therapist)

Phone

Place of work

Address

Postcode

Email

2. Name

Type

Phone

Place of work

Address

Postcode

Email

Birth details of person with CP

Birth place (e.g. Hornsby Hospital, home birth, birth centre)

If home birth, Unplanned ☐ Planned ☐ State

Birth weight | born at | weeks gestation

Hospital of neonatal transfer (if applicable)

State of hospital

Received more than routine care? ☐ Yes - NICU ☐ Yes - special care ☐ No - routine care only

If Yes, total length of stay days

Was MRI completed? Yes ☐ No ☐

Which hospital?

Was this a multiple birth? Yes ☐ No ☐

If Yes, twins ☐ triplets ☐ 4 ☐ 5 ☐ 6 ☐ >6 ☐

Birth order of child with CP (e.g. 2nd)

Was there any assistance with conception? (please tick)

- ☐ No
- ☐ Yes, type unknown
- ☐ Yes, if known please circle which type of assistance: fertility drugs only, ovulation stimulation only, artificial insemination, ICSI, IVF, GIFT
- ☐ Other

Number of previous live births to mother

Number of previous stillbirths (> 20 weeks gestation) to mother

Number of previous miscarriages (< 20 weeks gestation) to mother

Birth parent details

Mother

First name | Maiden name

Surname | DOB / /

Country of birth

Educational level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin

Father

First name

Surname | DOB / /

Country of birth

Educational level at time of child's birth

Occupation at time of child's birth

Aboriginal or Torres Strait Islander origin?

- ☐ Aboriginal but not Torres Strait Islander origin
- ☐ Torres Strait Islander but not Aboriginal origin
- ☐ Both Aboriginal and Torres Strait Islander origin
- ☐ Neither Aboriginal nor Torres Strait Islander origin

Clinical details of person with CP

(If you are unsure about any question, please leave blank)

Age at which CP was first formally diagnosed years ☐☐ months ☐☐

Type of cerebral palsy

(please tick)

	Main type at initial diagnosis	Main type at or over age 5	Secondary type at or over age 5
Spasticity			
Left hemiplegia / monoplegia	☐	☐	☐
Right hemiplegia / monoplegia	☐	☐	☐
Diplegia	☐	☐	☐
Triplegia	☐	☐	☐
Quadriplegia	☐	☐	☐
Dyskinesia			
Mainly athetosis	☐	☐	☐
Mainly dystonia	☐	☐	☐
Ataxia	☐	☐	☐
Hypotonia	☐	☐	☐
Resolved by age 5	☐	☐	
Known syndrome - not CP	☐	☐	
Unknown syndrome - not CP	☐	☐	
Unknown	☐	☐	☐

Severity of cerebral palsy

(please tick one)
(please see GMFCS sheet for further information)

	At initial diagnosis	At or over age 5
GMFCS level I	☐	☐
GMFCS level II	☐	☐
GMFCS level III	☐	☐
GMFCS level IV	☐	☐
GMFCS level V	☐	☐

Ability to handle objects in daily life

(please tick one)
(please see MACS sheet for further information)

	At or over age 4
MACS level I	☐
MACS level II	☐
MACS level III	☐
MACS level IV	☐
MACS level V	☐

Were any birth defects present?

(e.g. congenital heart defect)

No ☐ Yes ☐

If yes, please give details

Is there a known syndrome?

No ☐ Yes ☐

If yes, please give details

Presence of associated impairments (please tick one for each section)

Epilepsy
- ☐ Yes
- ☐ Resolved by age 5
- ☐ No
- ☐ Unknown

Intellectual
- ☐ No impairment
- ☐ Probably no impairment
- ☐ Probably some impairment
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Unknown

Visual
- ☐ No impairment
- ☐ Some impairment (e.g. glasses)
- ☐ Functionally blind
- ☐ Unknown

Strabismus ☐ No ☐ Yes ☐ Unknown

Hearing
- ☐ No impairment
- ☐ Some impairment (includes conductive hearing loss)
- ☐ Bilateral deafness
- ☐ Unknown

Speech
- ☐ No impairment
- ☐ Some impairment
- ☐ Nonverbal
- ☐ Unknown

Timing of cerebral palsy

- ☐ Unknown
- ☐ During pregnancy and up to first 28 days of life (pre & perinatal)
- ☐ After first 28 days of life (postnatal)

Was there a confirmed cause of cerebral palsy?

- ☐ Unknown
- ☐ In utero cytomegalovirus
- ☐ Other infection (toxoplasmosis, rubella, herpes simplex virus)
- ☐ Other infection (please list in comments)
- ☐ Other (please list in comments)

Head injury
- ☐ Motor vehicle accident
- ☐ Non accidental
- ☐ Fall
- ☐ Other (please describe in comments)

Infection
- ☐ Unspecified cause
- ☐ Viral
- ☐ Bacterial
- ☐ Dehydration due to gastroenteritis

Stroke or CVA
- ☐ During or following surgical procedure
- ☐ Spontaneous
- ☐ Associated with other cardiac complications

Other
- ☐ Post seizure
- ☐ Near sudden infant death syndrome (SIDS)
- ☐ Post immunisation
- ☐ Near drowning
- ☐ Peri-operative hypoxia
- ☐ Apparent life-threatening event
- ☐ Other (please describe in comments)

Comments

If you wish to make any further comments, please do so here:

I hereby verify that the above details are correct to the best of my knowledge, being the person with CP / a parent / the person responsible (please circle appropriate response).

Signature: Relationship: Date: / /