The Sturge-Weber and Neurocutaneous Service

Pre-visit Questionnaire

By filling in this questionnaire, you are helping us decide which team members will be necessary to assess your child, and giving us information which will be useful during our assessment.

Thank you for completing this form.

CHILD'S FULL NAME:	**Date of Birth:**	
	Age:	
	Sex:	**Male** ☐ **Female** ☐
Name of person completing this form:		
Your relationship to this child:		

What questions would you like to discuss at your visit?

1 ----------

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2 ----------

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3 ----------

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4 ----------

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5 ----------

If unable to complete, please select reason why:

- ☐ I don't have any specific questions
- ☐ I am unsure of the purpose of this clinic
- ☐ I find it difficult to write these down

SECTION 1– CHILD'S STRENGTHS AND DIFFICULTIES

What do you think are your child's strengths and interests (what does she/he like or do best)?

Please complete the following table by ticking Yes or No in each box:

Area of Development	Does your child have difficulties in this area?	Has your child received any help with this outside GOSH?	If yes, have you attached any relevant reports?
Language and Communication	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Learning	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Movement and Coordination	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Play and Social Skills	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Behaviour	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Independence	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Are there any further details you would like to add to any of the above?

SECTION 2 - CURRENT SITUATION

Education

Name and Area of School: _____ Year Level: _____

School Type:

Mainstream ☐
Special School ☐
Other ☐ **Please specify _____**

Does your child have a Statement of Special Educational Needs?

Yes ☐ **No** ☐

Does he/she receive additional support in school?

Yes ☐ **No** ☐

If Yes, Please give details:_____

Communication

What languages do you speak at home? **Please tick if this is the child's preferred language:**

1 (Main Language) _____ ☐

2 _____ ☐

3 _____ ☐

4 _____ ☐

Would you like an interpreter present at the clinic session?

Yes ☐ **No** ☐

Medication

Please complete the table of current medications for this child:

	Medication	Dose	Frequency
1			
2			
3			
4			
5			

Is there anything else it would be helpful for us to know about your child?

Other Professionals Involved

PLEASE LIST THE NAMES AND ADDRESSES OF KEY PROFESSIONALS WHO WERE RECENTLY, OR ARE CURRENTLY INVOLVED IN YOUR CHILD'S CARE:

	Name	Profession	Address, Postcode, Tel No. & Email (if known)	Tick to receive GOSH report
1				☐
2				☐
3				☐
4				☐
5				☐
6				☐

To complete our assessment to highest possible standard we may want to contact your local health team, e.g. occupational therapist, speech and language therapist.

☐ I _____ give consent for those listed above to be contacted before, during or after the appointment as required, and for specific persons selected to receive a copy of our report.

Please call 020 7405 9200 ext 1144 if you do NOT want us to contact any member of your local team.

SIGNED:	**DATE:**

Thank you for taking the time to complete this questionnaire.

Please kindly return this to GOSH as soon as possible.

SECTION 3 - BACKGROUND INFORMATION

(complete before 1st Clinic Appointment Only):

Hearing and Vision

Has your child's hearing ever been tested?

☐ No ☐ Yes: No issues found ☐ Yes: Issues Found

If issues found, please describe (including date of assessment):

Has your child's eyesight ever been tested?

☐ No ☐ Yes: No issues found ☐ Yes: Issues Found

If issues found, please describe (including date of assessment):

Developmental History

At what age did your child do the following ?

Speak his/her first words:

☐ Details not available ☐ Not yet observed

Walk without holding on:

☐ Details not available ☐ Not yet observed

Smile in response to your smile:

☐ Details not available ☐ Not yet observed

Talk in short sentences:

☐ Details not available ☐ Not yet observed

We use information gathered in this clinic to for research purposes. This is stored securely and anonymously. Participation in research does not in any way affect your child's clinical treatment at GOSH. Please let us know whether you give permission for us to store anonymous data about this child:

☐ Yes, I give permission ☐ No, I do not want details stored

☐ Undecided – I would like to discuss

SIGNED:	**DATE:**

Thank you for taking the time to complete this questionnaire.

Please kindly return this to GOSH as soon as possible.