SECTION A: HEALTH STATUS

1. Corrected Age at the follow-up visit (months/days): ___ ___ months ___ ___ days

SECTION B: LIVING SITUATION

2. Maternal Age at Infant Birth: ___ ___ years

3. Home Child Resides: □ Parent/Family member □ Foster care □ Institutional

4. Caregivers: 
   □ Single parent 
   □ Two parent 
   □ Single parent extended family 
   □ Two parent extended family 

   Check (✓) only one

5. Primary Caregiver Education: 
   □ Some High School or less 
   □ High School degree/GED 
   □ Not applicable 
   □ Some college/university 
   □ College/university degree 
   □ Unknown 

   Check (✓) only one

USA CENTERS ONLY

6. Income Below 2016 HHS Poverty Guideline: □ Yes □ No □ Unknown

7. Caregiver(s) Primary Language: □ English □ Spanish □ Other

<table>
<thead>
<tr>
<th>Persons</th>
<th>Income 2016 HHS Poverty Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(48 contiguous states and District of Columbia)</td>
</tr>
<tr>
<td>2</td>
<td>$ 16,020</td>
</tr>
<tr>
<td>3</td>
<td>$ 20,160</td>
</tr>
<tr>
<td>4</td>
<td>$ 24,300</td>
</tr>
<tr>
<td>5</td>
<td>$ 28,440</td>
</tr>
<tr>
<td>6</td>
<td>$ 32,580</td>
</tr>
<tr>
<td>7</td>
<td>$ 36,730</td>
</tr>
<tr>
<td>8</td>
<td>$ 40,890</td>
</tr>
<tr>
<td>Additional</td>
<td>$ 4,160</td>
</tr>
</tbody>
</table>


SECTION C: SUPPORT AFTER DISCHARGE

8. Any Outpatient Support: □ Yes □ No □ Unsure

   If yes, complete the following

   Any time after discharge

   At present clinic visit

   a. Tracheostomy: □ Yes □ No □ Unsure □ Yes □ No
   b. Ventilator: □ Yes □ No □ Unsure □ Yes □ No
   c. Oxygen: □ Yes □ No □ Unsure □ Yes □ No
   d. Gastrostomy: □ Yes □ No □ Unsure □ Yes □ No
   e. Nasogastric or Post-pyloric Feeds: □ Yes □ No □ Unsure □ Yes □ No
   f. Apnea or CP monitor: □ Yes □ No □ Unsure □ Yes □ No
   g. Pulse Oximetry: □ Yes □ No □ Unsure □ Yes □ No
   h. Respiratory Medications: □ Yes □ No □ Unsure □ Yes □ No
   i. Oral Feeding Support: □ Yes □ No □ Unsure □ Yes □ No
   j. Speech Support: □ Yes □ No □ Unsure □ Yes □ No
   k. Motor Support: □ Yes □ No □ Unsure □ Yes □ No

Complete form on reverse side
SECTION D: MEDICAL RE-HOSPITALIZATIONS AFTER DISCHARGE

9. Any Medical Readmissions (after ultimate discharge):
   [ ] Yes  [ ] No  [ ] Unsure
   If yes, complete the following

   a. Respiratory Illness:  [ ] Yes  [ ] No  [ ] Unsure
   b. Nutrition/ Failure to Thrive:  [ ] Yes  [ ] No  [ ] Unsure
   c. Seizure Disorder:  [ ] Yes  [ ] No  [ ] Unsure
   d. Shunt Complication:  [ ] Yes  [ ] No  [ ] Unsure
   e. Infections (not respiratory or shunt infections)
      i. Meningitis:  [ ] Yes  [ ] No  [ ] Unsure
      ii. Urinary Tract Infection:  [ ] Yes  [ ] No  [ ] Unsure
      iii. Gastrointestinal Infection:  [ ] Yes  [ ] No  [ ] Unsure
      iv. Other infection:  [ ] Yes  [ ] No  [ ] Unsure
         If yes, specify: __________________________________________________
   f. Other Medical Readmissions:  [ ] Yes  [ ] No  [ ] Unsure
      If yes, specify: __________________________________________________

SECTION E: SURGERIES

10. Surgical procedures (after ultimate discharge):
    [ ] Yes  [ ] No  [ ] Unsure
    If Yes, put all that apply
     # Procedures

   a. (P-Code) ________________________
   b. (P-Code) ________________________
   c. (P-Code) ________________________
   d. (P-Code) ________________________
   e. (P-Code) ________________________

SURGICAL PROCEDURE CODES (P-CODES)

<table>
<thead>
<tr>
<th>P-Code</th>
<th>Procedure</th>
<th>P-Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-101</td>
<td>Shunt or shunt revision for hydrocephalus</td>
<td>P-501</td>
<td>Otolaryngology Surgery</td>
</tr>
<tr>
<td>P-102</td>
<td>Other neurosurgical procedure</td>
<td>P-502</td>
<td>Tracheostomy</td>
</tr>
<tr>
<td></td>
<td>Congenital Heart Defect Surgery</td>
<td>P-503</td>
<td>Tympanostomy tubes</td>
</tr>
<tr>
<td>P-201</td>
<td>Cardiac surgery</td>
<td></td>
<td>Other ENT surgical procedure</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal Surgery</td>
<td></td>
<td>Ophthalmologic Surgery</td>
</tr>
<tr>
<td>P-301</td>
<td>Gastrostomy tube placement</td>
<td>P-601</td>
<td>Retinal cryosurgery or laser surgery: single eye</td>
</tr>
<tr>
<td>P-302</td>
<td>Inguinal hernia repair</td>
<td>P-602</td>
<td>Retinal cryosurgery or laser surgery: both eyes</td>
</tr>
<tr>
<td>P-303</td>
<td>Other gastrointestinal surgical procedure</td>
<td>P-603</td>
<td>Strabismus surgery</td>
</tr>
<tr>
<td></td>
<td>Genitourinary Surgery</td>
<td>P-604</td>
<td>Other ophthalmologic surgical procedure</td>
</tr>
<tr>
<td>P-401</td>
<td>Circumcision</td>
<td>P-900</td>
<td>Other Surgical Procedure</td>
</tr>
<tr>
<td>P-402</td>
<td>Other genitourinary surgical procedure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION A: GROWTH PARAMETERS
1. Corrected Age Growth Parameters Were Obtained (months/days): _______ months _______ days
2. Weight: _______ _______ _______ kg
3. Head Circumference: _______ _______ cm

SECTION B: VISION & HEARING
4. Post Discharge Eye Treatment: □ Laser □ Anti-VEGF □ Both □ Neither □ Unsure
5. Blindness: □ One eye □ Both eyes □ Neither □ Unsure
6. Prescription Glasses: □ Yes □ No
7. Hearing Impairment: □ One ear □ Both ears □ Neither □ Unsure
8. Amplification: □ Yes □ No

SECTION C: CEREBRAL PALSY
9. Cerebral Palsy: □ Yes □ No
   - If Yes, impairment: □ Diplegia □ Hemiplegia □ Quadriplegia
   - If No, muscle tone: □ Hypotonia □ Hypertonia □ Both □ Normal

SECTION D: GROSS MOTOR MILESTONES
10. Sits independently: □ Yes □ No
    - If No, sits with support: □ Yes □ No
11. Walks ten (10) steps independently: □ Yes □ No
    - If No, walks ten (10) steps with support: □ Yes □ No
12. Developmental Evaluation: □ Completed □ Partially completed □ Not done
    - If partially completed or not done, check (✓) why:
      - Neurosensory impairment □ Too severely delayed □ Uncooperative □ Other
    - If completed or partially completed, check (✓) which test:
      □ Bayley Scales of Infant Development-III □ Griffiths Mental Development Scales □ Other
13. Corrected Age Used In Scoring (months/days): _______ months _______ days

SECTION E: DEVELOPMENTAL TESTING
14. Results (BSID-III):
   - □ BSID-III Cognitive: □ BSID-III Language: (Sum) □ BSID-III Motor: (Sum)
     - Expressive Communication: (Sum) □ Receptive Communication: □ Gross Motor:
     □ Fine Motor: □ Not applicable
   - Composite Score
15. Results (GMDS):
   - □ Total Scale (GQ): □ Locomotor: □ Personal-Social: □ Hearing and Speech:
     □ Hand and Eye Coordination: □ Performance Tests:
   - Uncorrected Score
16. Clinical Appraisal:
   - Cognitive function: □ Normal □ Suspect □ Impaired
   - Language: □ Normal □ Suspect □ Impaired
   - Motor function: □ Normal □ Suspect □ Impaired