Birth-Injury Program Questionnaire

Patient name: ____

Birth Date: ___/_____/____ **Sex:** male female

Date of last history and physical examination: ___/____/____ [Enclose a copy of the H&P]

Epilepsy: Yes No **#Hours Daily Nursing Care:** _____ **Wheelchair Use (dependent):** Yes No

Daily Suctioning: Yes No **Tracheostomy:** Yes No **Ventilator:** Yes No

Gross Motor Function: [Indicate the highest level of skill that consistently applies]
- ❑ Does not walk; Does not lift head when lying on stomach
- ❑ Does not walk; Lifts head [and/or chest using arm support] when lying on stomach
- ❑ Does not walk; Rolls from side to side, front to back, or back to front
- ❑ Does not walk; Rolls front to back and back to front, or can sit on his/her own
- ❑ Walks with support of minimal equipment, such as cane or crutch, or list here: ___________
- ❑ Walks without support

Feeding Ability:
- ❑ Requires a feeding tube. If box is checked: Is the patient **NPO**: Yes No
- ❑ Does not feed self, must be fed completely; does NOT require a feeding tube
- ❑ Regularly finger feeds self, possibly with some food preparation by others
- ❑ Regularly feeds self using fork or spoon, possibly with spillage

Cognitive Impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐ Unknown

Therapies: □ PT □ OT □ ST □ Music □ Hippo □ Other _______________ □ Unknown

Vision: □ Good □ Fair □ Poor □ Legally Blind □ Unknown

Hearing: □ Good □ Deaf □ Uses Hearing Aids □ Unknown

Current Medical Issues / Hospitalizations / Operations (include calendar year or age)**:**

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Print name of MD here: ____

MD signature: ______________________________ Date: ___________________

Please return to: Virginia Birth-Injury Program Fax: 804-330-3054 Voice: 804-330-2471

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[Office use only] Claimant #: B ____ - ____

Computed life expectancy: ___________________

as determined by: _________________, PhD / ___________________, MD Date: ________