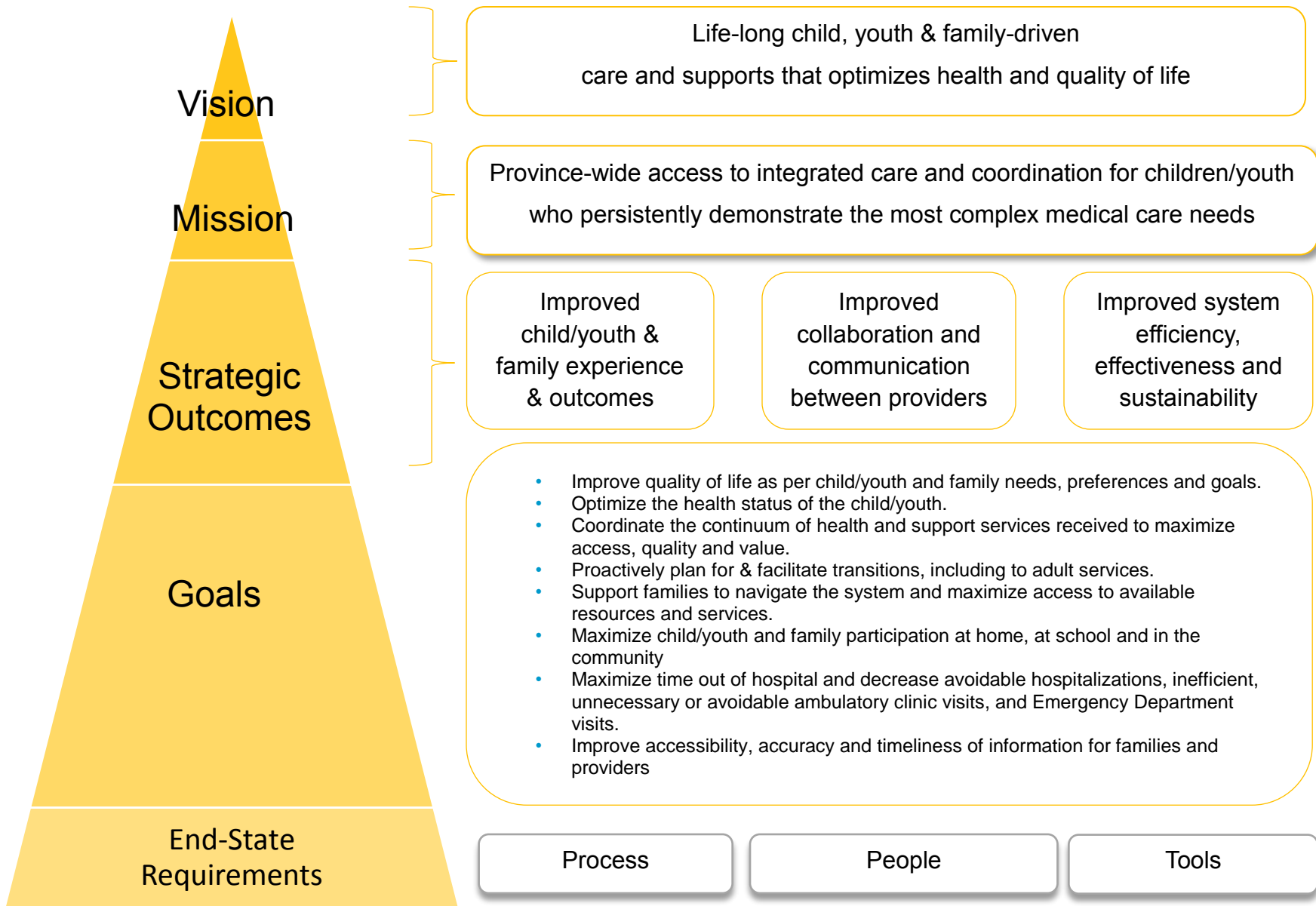


Appendix 1. Complex Care for Kids Ontario Strategic Framework[53]



Appendix 2. Complex Care for Kids Ontario Study Sites

Site Name	Location
The Hospital for Sick Children (SickKids)	Toronto, ON
Children's Hospital of Eastern Ontario	Ottawa, ON
London Health Sciences Centre	London, ON
Hamilton Health Sciences Centre	Hamilton, ON
North York General Hospital	Toronto, ON
Peterborough Regional Health Centre	Peterborough, ON
Orillia Soldiers' Memorial Hospital	Orillia, ON
Royal Victoria Hospital	Barrie, ON
Michael Garron Hospital	Toronto, ON
Credit Valley Hospital	Mississauga, ON

Appendix 3. Expense Diary

CQ1-EXTRACURRICULAR ACTIVITIES

CQ1a. Does your child participate in extracurricular activities (outings/sports/hobbies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ2a) <input type="checkbox"/> Don't Know (continue to CQ2a)
CQ1b How many hours of extracurricular activities does your child participate on average per month? (Describe to the best of ability)	_____ hours of activity on average per month

CQ2-ACADEMIC ACTIVITIES

CQ2a. Is your child currently enrolled in school outside the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____ (continue to CQ3a)
CQ2b. If Yes, does your child attend full-time (every day) or part time?	<input type="checkbox"/> Full-time (continue to CQd) <input type="checkbox"/> Part time (continue to CQ2c)
CQ2c. If your child attends school part time, how many days of school do they attend per week on average?	<input type="checkbox"/> 1 day <input type="checkbox"/> 2 days <input type="checkbox"/> 3 days <input type="checkbox"/> 4 days <input type="checkbox"/> N/A
CQ2d. Thinking back over the past 6 months, how many days of school does your child miss on average per month?	_____ days missed on average per month
CQ2e. Thinking back over the past 6 months, how much do you spend on travel to/from school for your child on average per month?	\$_____ on average per month AND Distance travelled daily to get child to schooling _____ km

CQ3. DOCTOR VISITS

These questions are only about when your child visited the doctor's office or clinic. This does not include emergency room visits or hospital stays.

CQ3a. Does your child use public transit, taxi or accessible transit services (e.g. Wheel trans)?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ3b)
CQ3ai. If your child uses public transit, taxi, or Wheel Trans, how much money do you usually spend traveling to and from the doctor's office/clinic per visit?	\$ _____
CQ3b. Do you or another family member drive to your child's doctor's office/clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ3c)
CQ3bi. If you or another family member drives, what is the distance to your child's doctor's office/clinic?	_____ km
CQ3c. On average how much do you spend on parking at the doctor's office/clinic?	\$ _____ per visit ----- ----- <input type="checkbox"/> Nothing <input type="checkbox"/> Not applicable

CQ4-INSURANCE COVERAGE

<p>CQ4a. Do you have a drug plan that pays for any of your child's medications (ie. Employee benefit package, Ontario Drug Benefit, OHIP+)?</p>	<p><input type="checkbox"/> Yes (continue to CQ5b) <input type="checkbox"/> No (continue to CQ5h) <input type="checkbox"/> Don't Know (continue to CQ5h)</p>
<p>CQ4b What is your Drug Plan?</p>	<p><input type="checkbox"/> 1. Employee benefit package <input type="checkbox"/> 2. Government program (ie. Ontario Drug Benefit, OHIP+) <input type="checkbox"/> 3. Other (Please specify:_____) <input type="checkbox"/> 4. Don't know, don't remember</p>
<p>CQ4c. When you have to pay for prescription drugs, what is the percentage of prescription medication costs that you pay on average?</p>	<p>_____ % <input type="checkbox"/> Don't know</p>
<p>CQ4d. Do you have a private health plan that covers other medical expenses such as physical therapy, ambulance services, medical devices etc?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ6a) <input type="checkbox"/> Don't Know (continue to CQ6a)</p>
<p>CQ4e. How much do you or your partner pay into this plan or how much is deducted from your pay cheque per month?</p>	<p>\$_____ per month <input type="checkbox"/> Nothing <input type="checkbox"/> Don't Know</p>

CQ6. MEDICAL DEVICES

CQ6a. Has your child needed to use any medical/assistance devices or equipment in the last 6 months (wheelchair, crutches, brace, syringes, VitaMix blender for special food preparation)?	<input type="checkbox"/> Yes (complete table below) <input type="checkbox"/> No
--	--

If yes, please list devices below:

Name of item	Reason [child] needs this	Financial coverage Check all that apply	If you paid some or all, please state the amount you paid (\$)
		<input type="checkbox"/> ADP (Assistive Devices Program) <input type="checkbox"/> Insurance <input type="checkbox"/> Self Paid <input type="checkbox"/> Donated	
		<input type="checkbox"/> ADP (Assistive Devices Program) <input type="checkbox"/> Insurance <input type="checkbox"/> Self Paid <input type="checkbox"/> Donated	
		<input type="checkbox"/> ADP (Assistive Devices Program) <input type="checkbox"/> Insurance <input type="checkbox"/> Self Paid <input type="checkbox"/> Donated	
		<input type="checkbox"/> ADP (Assistive Devices Program) <input type="checkbox"/> Insurance <input type="checkbox"/> Self Paid <input type="checkbox"/> Donated	

CQ7. EMERGENCY ROOM VISITS

These questions are only about when you had to bring your child to the emergency room. This does not include to doctor visits or to days when your child was admitted to the hospital.

CQ7a. Has your child gone to the hospital in an ambulance in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ8g)
CQ7b. How many times did your child do so?	_____ # of times
CQ7e. Did you have to pay for the ambulance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ8g) <input type="checkbox"/> Don't know/can't remember (continue to CQ8g)
CQ7f. How much did you spend on these ambulance services per visit?	\$ _____
CQ7g. Has your child gone to the emergency room by some other method of transportation in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ9)
CQ7h. How many times did your child do so?	_____ # of times
CQ7i. On average, how much did you spend on transportation to the emergency room (including parking, if applicable)?	\$ _____/visit

CQ8. HOSPITAL ADMISSIONS

These questions are only about when your child was admitted to hospital. This does not include emergency room visits.

CQ8a. Has been admitted to the hospital in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ10)
CQ8b. How many times was your child admitted to the hospital?	_____ # of times
CQ8c. On average, how much did you spend on transportation to the hospital (including parking, taxis, public transportation mileage)?	\$_____/day and Distance from home to hospital _____ km

CQ9. ALLIED HEALTH PROFESSIONALS AND SOCIAL SERVICE PROVIDERS

CQ9a. Has any allied health care or social service provider COME TO VISIT your child either at home, residence or school in the last 6 months? (See list of providers below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

Providers include:

- | | |
|---|---------------------------------------|
| - <i>Chiropractor</i> | - <i>Optometrist</i> |
| - <i>Psychologist</i> | - <i>Dentist</i> |
| - <i>Physiotherapist</i> | - <i>Social Worker</i> |
| - <i>Occupational Therapist</i> | - <i>Naturopath or Homeopath</i> |
| - <i>Speech Language Pathologist</i> | - <i>Adolescent/school counsellor</i> |
| - <i>Podiatrist or Chiropodist</i> | - <i>Children's aid</i> |
| - <i>Nutritionist or Dietitian</i> | - <i>Family counsellor</i> |
| - <i>Nurse Practitioner</i> | - <i>Support group</i> |
| - <i>Visiting Nurses (i.e., Home Care) or Private Nurse</i> | |

If yes, please list service provider below (please do not enter provider's name):

Type of Health Professional	Number of visits	Average Amount Spent per Visit (\$)	Self paid or insurance?
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____ <input type="checkbox"/> Don't know/can't remember
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____ <input type="checkbox"/> Don't know/can't remember
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____ <input type="checkbox"/> Don't know/can't remember

CQ9b. Has your child GONE TO VISIT any health care or social service provider at their place of practice (e.g. their office or at the hospital) in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

If yes, please list service provider below (please do not enter provider's name):

Type of Health Professional	Number of visits	Average Amount Spent per Visit (\$)	Self paid or insurance?	Average amount spent on parking per visit (\$)	Mileage (km)
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____		
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____		
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____		
	_____ average visits per month		<input type="checkbox"/> Self Paid <input type="checkbox"/> Insurance <input type="checkbox"/> Both If Both, what % by insurance? _____		

CQ10. LOSS OF TIME FROM WORK (PAID OR UNPAID)

CQ10a. Do you work in paid employment or are you on paid leave?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CQ10b. Do you participate in any volunteer activities or unpaid employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CQ10c. Thinking back over the past 6 months, have you had to miss any time from work/volunteer activities to go to the doctor, emergency room or while your child was admitted to the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ10e)
CQ10d. Thinking back over the past 6 months, can you estimate on average how many days per month have you had to take off?	_____ average days per month
CQ10e. Thinking back over the past 6 months, when your child went to the doctor, emergency room or was admitted to the hospital, has anyone else (such as another caregiver) had to miss time from paid employment to help you care for your child or accompany your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ10g) <input type="checkbox"/> Not applicable
CQ10f. Thinking back over the past 6 months, can you estimate on average how many days per month this other person had to take off each month?	_____ average days each month
CQ10g. Thinking back over the past 6 months, have you had to pay someone to care for your child (child in study) so that you could continue with your normal activities/homemaking or paid/unpaid employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ10i) <input type="checkbox"/> Don't know/Can't remember
CQ10h. Thinking back over the past 6 months, can you estimate on average how much you spent on this childcare per month?	Average spent per month \$: _____ <input type="checkbox"/> Don't know/Can't remember
CQ10i. Thinking back over the past 6 months, were you or other family members prevented from engaging in any activities such as shopping, volunteer, work, visiting friends, going to the movies, etc. to care for your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ10k) <input type="checkbox"/> Don't know/Can't remember
CQ10j. Thinking back over the past 6 months, can you estimate on average how many days per month this was?	_____ average days per month
CQ10k. Thinking back over the past 6 months, were you or other family members prevented from engaging in your regular homemaking tasks to care for your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to CQ10m)

	<input type="checkbox"/> Don't know/Can't remember
CQ10l. Thinking back over the past 6 months, can you estimate on average how many days per month this was?	_____ average days per month
CQ10m. Thinking back over the past 6 months, have you had to pay for any individual to assist you with homemaking activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to CQ10o) <input type="checkbox"/> Not applicable
CQ10n. Thinking back over the past 6 months, can you estimate on average how much you spent per month on assistance with homemaking activities?	Amount spent per month \$ _____
CQ10o. Thinking back over the past 6 months, have you had to pay for any individual to care for your other children while you were caring for child in study?	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to CQ11a) <input type="checkbox"/> Don't know/Can't remember
CQ10p. Thinking back over the past 6 months, can you estimate on average how much you spent childcare per month?	Amount spent per month \$ _____ <input type="checkbox"/> Don't know/Can't remember

CQ11 – CHANGES TO HOME SUCH AS RENOVATIONS

CQ11a. Have you had to do any changes to your home such as renovations (a ramp or a special bed) to accommodate your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ12)
CQ11b. How much in total did you pay for these changes to your home?	\$_____ spent in total on home renovations
CQ11c. What percentage of these costs were covered by other funding sources?	_____%

CQ12 – ACCESSIBLE VAN/VEHICLE

CQ11a. Have you had to purchase an accessible van/vehicle to accommodate your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No (continue to CQ13)
CQ11b. How much in total did you pay for the accessible van/vehicle?	\$_____ spent in total on accessible vehicle
CQ11c. What percentage of these costs were covered by other funding sources?	_____%

CQ13 – OTHER ONE-TIME EXPENSES

CQ13a. Have you had any other one-time expenses to accommodate your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
CQ13b. What is the total of these costs?	\$_____ spent in total on other one-time expenses?

Appendix 4. List of Institute for Clinical Evaluative Sciences (ICES) Datasets

Dataset Name	Dataset Description
ADP	Assistive Devices Program: program which covers customized equipment and specialized supplies for low-income and most medically high-risk children - costing data for equipment and supplies
DAD	Discharge Abstract Database: hospital diagnostic codes
HCD	Home Care Database: provincial government in-home provider and case-management visits – home care data
IPDB	ICES physical database: care provider information
LHIN	Local Health Integration Network: coding and geography data
NACRS	National Ambulatory Care Reporting System: emergency and same-day surgery data
ODB	Ontario Drug Benefit: program which covers medications for low-income and most medically high-risk children – medication costing data
OHIP	Ontario Health Insurance Plan: physician billing – costing data
OMHRS	Ontario Mental Health Reporting System: mental health care services use data
PCCF	Postal Code Conversion File: geography data
RPDB	Registered Persons Database: demographic and vital statistic data for all Ontario residents eligible for public health insurance

DEMOGRAPHIC QUESTIONS

Site/Study ID: _____

Date m / m / d / y y y y

Child's Birthday: _____ / _____
mm yyyy

Child's Gender:

- Male
- Female
- Inter-sex
- Other

DQ1. What is your relationship to the child?

- Mother
- Father
- Guardian
- Sister
- Brother
- Relative (please specify: _____)
- Stepmother
- Stepfather
- Other (please specify: _____)

DQ2. What is your sex?

- Female
- Male

DQ3. What is your age?

_____ years old

DQ4. Were you born in Canada?

- Yes * go to DQ5
- No

DQ5. When did you immigrate to Canada?

Year: _____

DQ6. How would you describe your ethnic background?

- African
- Asian
- Canadian
- Caribbean/ West Indian
- East European
- European
- South Asian

DEMOGRAPHIC QUESTIONS

Site/Study ID: _____

Date m m/d d/y y y y

Other (please specify: _____)

DQ7. What language is spoken most often at home?

- | | |
|---|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> French | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Gujarati | <input type="checkbox"/> Tamil |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Mandarin/Cantonese | <input type="checkbox"/> Other (please specify:_____) |
| <input type="checkbox"/> Persian | |
| <input type="checkbox"/> Polish | |

DQ8. What is your marital status?

- Married or living common-law
- Single (never been married)
- Widow or widower
- Separated or divorced

DEMOGRAPHIC QUESTIONS

Site/Study ID: _____

Date m m/d d/y y y y

DQ9. What is the highest level of education that you have attained?

- Elementary school (some or completed)
- Some secondary/high school
- Completed secondary/high school
- Some post-secondary (university or college)
- Received university or college degree/diploma

DQ10. What is the highest level of education that your spouse / partner has attained?

- Elementary school (some or completed)
- Some secondary/high school
- Completed secondary/high school
- Some post-secondary (university or college)
- Received university or college degree/ diploma
- Not applicable

DQ11. Which best describes your current employment status?

- | | |
|---|---|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed full-time (self-employed) | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Receiving social assistance |
| <input type="checkbox"/> Employed part-time (self-employed) | <input type="checkbox"/> Receiving disability or retirement pension |
| | <input type="checkbox"/> Student |

DQ12. Which best describes your spouse's/partner's current employment status?

- Employed full-time
- Employed full-time (self-employed)
- Employed part-time
- Employed part-time (self-employed)
- Unemployed
- Homemaker
- Receiving social assistance
- Receiving disability or retirement pension
- Student
- Not applicable

DEMOGRAPHIC QUESTIONS

Site/Study ID: _____

Date m m/d d/y y y y

DQ12. Including yourself, how many members are there living in your home?

Number of persons: _____

Appendix 6

Baseline Clinical Info (RA to Complete)

Study ID _____

Demographic Questions

Child's month of birth

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

Child's year of birth

- 2018
- 2017
- 2016
- 2015
- 2014
- 2013
- 2012
- 2011
- 2010
- 2009
- 2008
- 2007
- 2006
- 2005
- 2004
- 2003
- 2002
- 2001
- 2000
- 1999
- 1998

What is child's biological sex?

- Male
- Female
- Intersex

What is child's ethnic background?

- African
- Asian
- Canadian
- Caribbean/West Indian
- East European
- European
- South Asian
- Don't Know
- Other

If other, please specify: _____

Child in group home (residential care)?

- Yes
 No

Child in foster care?

- Yes
 No

Did this participant change institutions for the duration of the study?

- Yes
 No

If yes, what is their new institution?

- Sickkids
 McMaster
 CHEO
 London
 North York General
 Royal Victoria
 Orillia
 Peterborough
 Michael Garron
 Credit Valley

Parent Demographics

Parent's age

Important Dates

Date of randomization (YYYY-MM-DD)

Date of consent (YYYY-MM-DD)

Date of baseline questionnaire completion (YYYY-MM-DD)

Baseline Hospitalization

Was the child admitted as an in-patient in the time period between randomization, consent, and baseline questionnaire completion?

- Yes
 No

If the child was an in-patient during this time period, how many times were they hospitalized?

- 1
 2
 3
 4
 5

Hospitalization 1: date of admission (yyyy-mm-dd)?

Hospitalization 1: date of discharge (yyyy-mm-dd)?

Hospitalization 1: length of hospitalization (in days)

Hospitalization 2: date of admission (yyyy-mm-dd)?

Hospitalization 2: date of discharge (yyyy-mm-dd)?

Hospitalization 2: length of hospitalization (in days)

Hospitalization 3: date of admission (yyyy-mm-dd)?

Hospitalization 3: date of discharge (yyyy-mm-dd)?

Hospitalization 3: length of hospitalization (in days)

Hospitalization 4: date of admission (yyyy-mm-dd)?

Hospitalization 4: date of discharge (yyyy-mm-dd)?

Hospitalization 4: length of hospitalization (in days)

Hospitalization 5: date of admission (yyyy-mm-dd)?

Hospitalization 5: date of discharge (yyyy-mm-dd)?

Hospitalization 5: length of hospitalization (in days)

Diagnosis

What is the child's primary diagnosis?

What are the child's secondary diagnoses?

Medication

Does the child take any medication?

- Yes
 No

Number of medications:

- 1
 2
 3
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19
 20

Medication 1: Name of Medication _____

Reason for medication: _____

Medication 2: Name of Medication _____

Reason for medication: _____

Medication 3: Name of Medication _____

Reason for medication: _____

Medication 4: Name of Medication _____

Reason for medication: _____

Medication 5: Name of Medication _____

Reason for medication: _____

Medication 6: Name of Medication _____

Reason for medication:

Medication 7: Name of Medication

Reason for medication:

Medication 8: Name of Medication

Reason for medication:

Medication 9: Name of Medication

Reason for medication:

Medication 10: Name of Medication

Reason for medication:

Medication 11: Name of Medication

Reason for medication:

Medication 12: Name of Medication

Reason for medication:

Medication 13: Name of Medication

Reason for medication:

Medication 14: Name of Medication

Reason for medication:

Medication 15: Name of Medication

Reason for medication:

Medication 16: Name of Medication

Reason for medication:

Medication 17: Name of Medication

Reason for medication:

Medication 18: Name of Medication

Reason for medication:

Medication 19: Name of Medication

Reason for medication:

Medication 20: Name of Medication

Reason for medication:

Diet

Which best describes the child's diet?

- Oral
- G tube
- Oral and G tube

Please describe the details of their [child_diet] diet:

Medical/Technology Devices

Does the child use any medical or technology devices?

- Yes
- No

Number of medical devices:

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Please select all the medical/technology devices the child is currently using:

Feeding

- G Tube
- GJ Tube
- NG Tube

Respiratory

- Nebulizer
- Oxygen
- CPap
- BiPap
- Tracheostomy
- Ventilation
- Suction

Mobility

- Wheelchair
- Special Stroller
- Special Seating
- Walker/Stander
- Prosthetics
- Ankle and foot orthotics

Other

- Hearing Aid
- Glasses
- Feeding pump
- Wheelchair van
- Mechanical lift
- Oxygen saturation monitors
- Other

If other, please specify:

Communication

Is the child older than 12 months?

- Yes
- No

How would you describe their communication skills?

- Verbal
- Non-verbal

Gross Motor Functioning

Does the child have difficulties with gross motor functioning?

- Yes
 - No
-

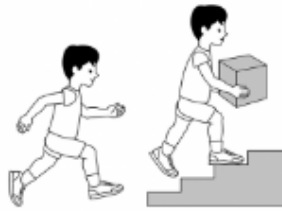
Is the child older than 2 years of age?

- Yes
 - No
-

Using the Gross Motor Function Classification System (GMFCS), how would you describe the child's current level of motor functioning?

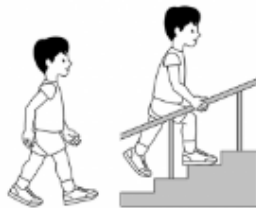
- Level I
- Level II
- Level III
- Level IV
- Level V
- N/A

Gross Motor Function Classification System (GMFS):



GMFCS Level I

Children walk at home, school, outdoors and in the community. They can climb stairs without the use of a railing. Children perform gross motor skills such as running and jumping, but speed, balance and coordination are limited.



GMFCS Level II

Children walk in most settings and climb stairs holding onto a railing. They may experience difficulty walking long distances and balancing on uneven terrain, inclines, in crowded areas or confined spaces.

Children may walk with physical assistance, a handheld mobility device or used wheeled mobility over long distances. Children have only minimal ability to perform gross motor skills such as running and jumping.



GMFCS Level III

Children walk using a hand-held mobility device in most indoor settings. They may climb stairs holding onto a railing with supervision or assistance. Children use wheeled mobility when traveling long distances and may self-propel for shorter distances.



GMFCS Level IV

Children use methods of mobility that require physical assistance or powered mobility in most settings. They may walk for short distances at home with physical assistance or use powered mobility or a body support walker when positioned. At school, outdoors and in the community children are transported in a manual wheelchair or use powered mobility.



GMFCS Level V

Children are transported in a manual wheelchair in all settings. Children are limited in their ability to maintain antigravity head and trunk postures and control leg and arm movements.

Hospital Visits

Over the past year..

How many hospital visits has the child had?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28
- 29
- 30
- 31
- 32
- 33
- 34
- 35
- 36
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45
- 46
- 47
- 48
- 49
- 50
- 50+

If there were over 50 hospital visits, please specify the number:

How many of these were clinic visits:

How many of these were diagnostic visits?

How many of these were emergency visits:

How many of these were day surgery visits:

Misc Comments
