Follow-Up Questionnaire (interview after informed consent)

Study Number____
Interview Date_____________ Interview Starting Time_____________
Interviewer_________________ Name of Parent Interviewed_______

Demographic Details:

Family Name_________Given Name_____________ID Number_________
Birth Date_______Child’s Current Age____________ Date of disease onset__________

Educational Setting

1. What is the educational setting in which the child is generally found?
2. Is this Institution a Day Care/Preschool/Elementary School/High School?
   Other________________________________
3. What type of education setting is this? Regular Education/Special Education
4. Is your child eligible for an educational assistant yes/no
5. If so, for how many hours per day?
6. If so, do you use the assistant? Yes No
7. Does your child require tutoring or assistance with homework?

Hearing Issues (Refers to time period after illness)

8. Did you child have any hearing problems prior to the illness?
9. After the illness, was a hearing test performed? Yes No If no, why?
10. Number of hearing tests done
11. Location of most recent hearing test
12. Was there a hearing loss? Yes No if so, was it mild/moderate/severe
13. Results of test in right ear
14. Results of test in left ear
15. Does your child use a hearing aid? Yes No
16. Has you child undergone an operation to improve their hearing? Yes No
   If so, which________________________________
17. Has your child received another treatment (e.g. speech therapy) Yes No

Neurological Deficits

18. Has your child been followed by a neurologist before the illness? Yes No
19. Is your child being followed by a neurologist now? Yes No
   If so, Please list the reason or diagnosis
20. Is your child now or in the past seen in a Child Development Center? Yes No
   If so, please specify the diagnoses
21. Does your child suffer from seizures? If so, what medication does he/she receive?
22. Does your child suffer from problems in any of the following areas (circle all that apply) – Memory, Concentration, Attention, Language Delay
   Have they been diagnosed as having: Dysarthria, Dyslexia, and Dysgraphia?
23. Does your child suffer from chronic headaches? Yes No
24. Does your child suffer from behavioral problems? If so, please specify
25. After the illness, did your child develop hydrocephalus? Yes No
   If so, did he/she have a shunt placed? Yes No
26. If so, have there been episodes of shunt obstruction? Yes No

Mobility

27. Does your child suffer from any motor difficulties? Yes No
28. Does your child have any problems with walking or mobility? If so, please specify
29. Does your child need any adaptive equipment for the purpose of mobility?

Special Support Eligibility

30. Is your child eligible for a disability grant from the National Insurance?
   If so, what is the percentage of eligibility? 50% 100% 150%
31. Does your family have added expenses since the illness?

General Health Status

32. Has your child suffered from an illness that required hospitalization? Yes No
   If yes please specify:
   Date of hospitalization
   Place of hospitalization
   Cause of hospitalization
33. Is your child getting physical therapy or other treatments? If so, specify
   In what setting is your child getting these treatments?

Do we have your permission to contract the child’s primary care provider? Yes No
If yes, contact details.

Thank you
Interview ending Time__________ Physician signature_____________