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| Kidz First Ambulatory Care |
| Neurodevelopmental Team |
| Module 4 |
| Manukau SuperClinic |
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Telephone: **09 250 8014** Fax: **09 277 1633**

Email: **MSCRECPT4@middlemore.co.nz**

**PRESCHOOL OBSERVATIONS**

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| **Name of Child** (given name and surname)  **Date of Birth** DD**/**MM**/**YYYY **GENDER**  Male  Female  **Centre/School Name**  **Centre/School Address**    **Telephone** **Landline**  **Mobile**  **Email**  **Key Staff Member for Contact\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Form completed by ( As above )**  **Position** **Date** DD**/**MM**/**YYYY | | | |
| **Attendance** | | | |
| How long has the child attended there? Year(s) Months  Does the child have a good attendance record?  Yes  No  (if no, please comment)  How did the child settle in at first?    What, if any, extra supports have been put in place? | | | |
| **Performance and skills** | | | |
| Please provide a brief description of the child’s strengths:      Please provide a brief description of the child’s difficulties/ your concerns : | | | |
| **Daily living** | | | |
| How is the child managing routines such as meal times, dressing and toileting? | | | |
| **General behaviour and play** | | | |
| Please comment on the child’s general behaviour, mood/s, and sensory responses:        Please comment on the child’s play, activity preferences, and flexibility with transitions:      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Social interactions** | | | |
| How does this child relate to adults?        How does this child relate to other children, and how do they respond to him or her?      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Verbal Communication** | | | |
| Please describe the child’s understanding and use of words (e.g. single words/phrases?) | | | |
| **Non-Verbal Communication** | | | |
| Please describe the child’s use of gesture, pointing and facial expressions:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Supports provided** | | | |
| Has the child seen or been considered for any of the following ( I don’t know): | | | |
|  | **Referred** | **Assessed** | **Name of Professional** |
| Psychology | **DD/MM/YYYY** | Yes  No  Yes  No  Yes  No  Yes  No  Yes  No |  |
| Speech therapist | **DD/MM/YYYY** |  |
| Occupational/Physiotherapy | **DD/MM/YYYY** |  |
| Early Intervention Service | **DD/MM/YYYY** |  |
| Other | **DD/MM/YYYY** |  |
| **Compare the child’s performance in comparison to that of other children of the same age:** | | | |
| Do you have concerns regarding...  Vision/Hearing Yes  No  Movement Skills Yes  No  General Learning Yes  No  Attention/concentration Yes  No  Challenging Behaviour Yes  No  General Child Well-being Yes  No  Family Well-being Yes  No  Other Yes  No | | Comments | |
| **Other information and/or concerns:** | | | |
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**Thank you for completing this questionnaire.**

**Please return completed form to:** Module 4, Manukau SuperClinic Email: [MSCRECPT4@middlemore.co.nz](mailto:MSCRECPT4@middlemore.co.nz) or Fax: 09 277 1633.