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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) MonthsDoes 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 [ ]  NoMovement Skills [ ] Yes [ ]  NoGeneral Learning [ ] Yes [ ]  NoAttention/concentration [ ] Yes [ ]  NoChallenging Behaviour [ ] Yes [ ]  NoGeneral Child Well-being [ ] Yes [ ]  No Family Well-being [ ] Yes [ ]  No Other [ ] Yes [ ]  No | Comments        |
| **Other information and/or concerns:** |
|    |

**Thank you for completing this questionnaire.**

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