1. Type(s) of rehabilitation therapy discipline received:(choose all that apply)

Speech/ Language

Occupational

Physical

Psychological

Behavioral

Vision

Recreational

Developmental Instruction

Respiratory

Social work/case management

Other, specify

None

1. For each discipline received in question1 above:
   1. Rehabilitation therapy service:

Outpatient

Early Intervention

School-based

Inpatient – acute medical unit

Inpatient – acute rehabilitation unit (define as ≥3 hrs of rehab therapies daily?)

Inpatient – subacute rehabilitation unit (define as <3 hrs of rehab therapies daily?)

Other

* 1. Rehabilitation therapy location:

Short term/ general hospital for inpatient medical care

Inpatient rehabilitation facility/ unit

Clinic/ facility for outpatient care

Patient’s home

School

Day care

Residential facility

Other community facility

Other

* 1. Therapy episode start date: mm dd yyyy
  2. Therapy episode end date: mm dd yyyy
  3. Age at start of episode of rehabilitation (years, round to first decimal place)
  4. Total number of sessions
  5. Average duration of sessions (minutes)
  6. Content of \_\_\_\_ therapy

| Activity | Activity | Activity |
| --- | --- | --- |
| Assessment /evaluation | Self-feeding | Complementary approaches |
| Bed mobility | Grooming | Pain management |
| Transfers | Bathing | Airway / respiratory management |
| Wheelchair mobility – manual | Dressing, upper body | Tracheostomy tube and/or ventilator support |
| Wheelchair mobility – power | Dressing, lower body | Psychosocial support |
| Postural control/balance training | Toileting for clothing management and hygiene | Psychotherapeutic intervention |
| Pre-gait | Communication interventions | Psychoeducation intervention |
| Gait | Assistive technology | Patient/caregiver education |
| Range of motion / stretching | Home management skills | Discharge planning |
| Endurance | Other therapeutic activities | Financial planning |
| Strengthening | Modalities | Supportive counseling |
| Motor control training | Community re-integration outing | Peer/advocacy group |
| Constraint-induced movement training | Developmental skills | Community / in-house services |
| Bimanual movement training | Aquatic therapy | Leisure skills |
| Musculoskeletal interventions | Social skills | Leisure education and counseling |
| Skin/wound management | Motor speech and/or voice disorder interventions | Team and patient / family conference |
| Equipment evaluation | Swallowing/feeding trials | Team process (interdisciplinary team interactions/planning) |
| Equipment provision / modification/ education | Swallowing/feeding exercises | Other ( specify) |
| Splint / cast fabrication | Cognitive-communication interventions |

1. \*Provided with new mobility device?  Yes  No  Unknown

IF YES, type(s) of mobility devices: (choose all that apply)

Forearm crutch – unilateral

Forearm crutches – bilateral

Quad cane – unilateral

Quad cane – bilateral

Walker – posterior

Walker – anterior

Gait trainer

Power wheelchair

Manual wheelchair

Manual-assist wheelchair

Scooter

Other, specify:

None

1. Provided with new positioning devices?  Yes  No  Unknown

IF YES, type(s) of positioning devices: (choose all that apply)

Wrist splints – day use

Wrist splints – night use

Ankle/foot orthosis – day use

Ankle/foot orthosis – night use

Submalleolar orthosis

Abduction wedge

Knee immobilizer(s)

Stander

Positioning/feeding chair

Compression garment

Other upper extremity device

Other lower extremity device

Adaptive or Activities of Daily Living (ADL) equipment

Other, specify:

None

1. Provided with new communication device?  Yes  No  Unknown
2. IF YES, type(s) of communication devices: (choose all that apply)

Eye gaze

Touch screen

Voice recognition

Other

None

1. Provided with durable medical equipment?  Yes  No  Unknown

IF YES, type(s) of durable medical equipment: (choose all that apply)

Hospital bed

Raised toilet seats

Bedside commode

Shower/bath equipment

Suction devices

Oxygen

Other, specify:

None

1. Provided with home modifications?  Yes  No  Unknown

IF YES, type(s) of durable medical equipment: (choose all that apply)

Bathroom renovations (i.e., grab bars, hand held shower head)

Stair lift

Exterior ramp

Elevator

Other, specify:

None

1. Received adjunctive treatments?  Yes  No  Unknown

IF YES, type(s) of adjunctive treatments: (choose all that apply)

Feeding/ gastrostromy tube placement

Botulinum toxin for spasticity

Intrathecal baclofen

Tracheostomy

Tendon lengthening or transfer

Contracture release

Surgical procedure for drooling, specify:

Other, specify:

None

## Follow-up Care

1. Follow-up care from primary care physician?  Yes  No  Unknown
2. Follow-up care from rehabilitation physician?  Yes  No  Unknown  Not applicable
3. Follow-up care from orthopedic surgeon?  Yes  No  Unknown  Not applicable
4. Follow-up care from other physician?  Yes  No  Unknown

## General Instructions

This case report form (CRF) contains data elements related to rehabilitation therapies and other follow-up care the participant/subject receives.

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.

Important note: None of the data elements included on this CRF are considered Core (i.e., strongly recommended for all studies to collect). These data elements are supplemental and supplemental – highly recommended (\*) and should be collected on clinical trials and only if the research team considers them appropriate for their study.