DOLFIN
Developmental Outcomes of Long-term Feed Supplementation in Neonates

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

For completion by the DOLFIN Trial Office

Study number: | | | | | | |

Child's name:

DOLFIN 24 Month Questionnaire

No one knows your child like you do. That is why we would like you to tell us how your child is getting on now they have reached 24 months since their expected date of delivery.

The questions in this questionnaire ask about your health, and your child's health and development. It also asks about any extra care your child has had, and about your family circumstances.

All of this information is very important for the study. It will be used to help us find out whether adding a daily nutritional supplement to babies' milk and weaning foods can help their brain development and neurological child development. The questions about your family circumstances will help tell us whether the supplement has a wider effect on you and your family.

This questionnaire may take up to an hour to complete. To answer the questions from the Ages and Stages Questionnaires®-3 on pages 9 and 10, you may need to try the activities with your child before you can answer. Please have a look at these questions before you complete this questionnaire so that you know if this will be needed.

These questionnaires should be completed by the same person each time, preferably the child's mother as some of the questionnaires ask about the mother's quality of life. Where this is not possible, please let us know below who completed the form.

This form was completed by the child's:

Mother ☐ Father ☐ Another person with parental responsibility ☐

Date form completed: D D / M M / Y Y

DOLFIN Questionnaire - 24 Months

Section 1: Your child's health and physical development

The following questions ask about your child's health and physical development. **Please answer all of the questions as best you can**. You may feel that some of these questions do not apply to your child, but it is important to answer them all so we can find out about your child's general health and development.

1. **In general, how is your child's health compared with other children of the same age?** *(please choose one)*

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

2. **Does your child have any difficulties with his or her hearing?** *(please choose one, but if they intermittently suffer from glue ear please report what their hearing is like when this is less problematic)*

- [ ] No difficulties
- [ ] Has some difficulty but does not need a hearing aid or hearing implant
- [ ] Has some difficulty and is being assessed/is waiting for a hearing aid/hearing implant
- [ ] Has a hearing aid/hearing implant and hears well with it
- [ ] Has difficulty hearing, even with a hearing aid/hearing implant
- [ ] My child is deaf

3. **Does your child have any difficulties with his or her vision?** *(please choose one)*

- [ ] No difficulties
- [ ] Needs to wear glasses, and sees well when wearing them
- [ ] Has difficulty seeing, even when wearing glasses
- [ ] Is blind in one eye but has good vision in the other eye
- [ ] Is able to see light only or is blind

4. **Is your child able to walk on his or her own, without any support?** *(please choose one)*

No difficulties walking alone ☐

Can walk a few steps without any help ☐

Can only walk if helped by an adult or a walking aid ☐

Unable to walk even with help ☐

5. **Is your child able to sit *on the floor* on his or her own, without any support?** *(please choose one)*

No difficulties sitting alone ☐

Can sit alone but is unstable (may need to use his or her hands for support) ☐

Can only sit with support or with help from an adult ☐

Unable to sit ☐

6. **Has your child been given a diagnosis of Cerebral Palsy by a doctor or other health professional?** *(please choose one)*

Yes ☐

No ☐

A health professional has said my child may have Cerebral Palsy but we are waiting for a definite diagnosis ☐

Section 2: Parent Report of Children's Abilities - Revised
Your child's play

As a parent, you will have a good idea of what your child can and can't do. Listed below are a number of activities. Please indicate whether or not your child can do the activity. That is, if you have seen your child do the activity (or a similar activity) then choose the box under 'Yes'. If you know that your child would not be able to do it, then choose the box under 'No'. If you are not sure whether or not your child can do it, then choose the box under 'Don't know'.

Please answer every question.

Please keep in mind that these questions are for children ranging from 18 months to 4 years of age. Some activities may be easy for your child, others may be difficult. Most children of your child's age will not be able to do some of the activities.

	Yes	No	Don't Know
1. Does your child copy things you do such as cuddling a teddy? (Try it out if you are not sure by cuddling a teddy and then giving it to your child. Say: Now you cuddle teddy)	☐	☐	☐
2. When you hide a toy in full view of your child, will s/he look for it and find it? (Try this out by covering a small toy with a cloth or a cup and seeing if s/he uncovers it)	☐	☐	☐
3. Can your child put a simple piece, such as a square or an animal, into the correct place in a puzzle board?	☐	☐	☐
4. Some toys have several holes or openings with different shapes, such as a circle, triangle, and star. Could your child put the shapes into the right openings?	☐	☐	☐
5. Can your child stack two small blocks or toys on top of each other?	☐	☐	☐
6. Can your child put together, by him/herself, a puzzle or something similar where the pieces fit together?	☐	☐	☐
7. If so, can s/he do this for a puzzle with ten or more pieces?	☐	☐	☐
8. Can your child mark on a piece of paper using the tip of a crayon, pencil, or chalk?	☐	☐	☐
9. Can your child draw a more or less straight line on paper?	☐	☐	☐
10. Does your child turn, or try to turn, the pages of a book one at a time?	☐	☐	☐
11. Does your child ever pretend that one object, such as a block, is another object, such as a car or a telephone?	☐	☐	☐
12. Can your child stack three small blocks or toys on top of each other by him/herself?	☐	☐	☐
13. Does your child ever pretend to do things? For example, riding a horse or making a cup of tea?	☐	☐	☐
14. Can your child push a car along the floor with the wheels on the floor?	☐	☐	☐
15. Does your child look with interest at pictures in a book?	☐	☐	☐

	Yes	No	Don't Know
16. Does your child point to pictures in a book?	☐	☐	☐
17. Does your child try to copy things you do, such as stirring with spoon in a cup?	☐	☐	☐
18. Can your child stack seven small blocks or toys on top of each other by him/herself?	☐	☐	☐
19. Does your child point or show where people or objects are when you ask? For example, "Where is the light?", "Where is Daddy?" or "Where is Teddy?"	☐	☐	☐
20. Does your child ever pretend that two dolls are playing together, or are talking to each other, or one is feeding the other?	☐	☐	☐
21. Does your child ever play pretend games with another child, pretending to be someone else, such as a mummy, daddy, policeman, or nurse?	☐	☐	☐
22. Does your child ever play any game with another child that involves taking turns?	☐	☐	☐
23. Does your child ever copy some action shortly (within a few minutes) after s/he has seen it?	☐	☐	☐
24. Can your child fetch something, such as a toy, from another room by him/herself when you ask?	☐	☐	☐
25. Does your child know where some things belong, such as that his/her toys belong in a box?	☐	☐	☐
26. Does your child ever save or put to one side a biscuit (or snack) for later, on his/her own?	☐	☐	☐
27. Have you ever seen your child get together 3 or more toys before beginning to play with them?	☐	☐	☐
28. Have you ever seen your child sort things (blocks, other toys) into groups or piles that go together on his/her own?	☐	☐	☐
29. If your child wants something out of reach, does s/he go and find a chair or box to stand on?	☐	☐	☐
30. When your child uses or plays with a telephone, does s/he speak into the mouthpiece not the earpiece?	☐	☐	☐
31. When your child drinks from a cup, is s/he careful about putting it down, trying not to spill it?	☐	☐	☐
32. Does your child try to turn doorknobs, twist tops, or screw lids on or off jars?	☐	☐	☐
33. Does your child recognise him/herself when looking in the mirror?	☐	☐	☐
34. Does your child ever use his or her index (first) finger to point to show an interest in something?	☐	☐	☐

Section 3: Parent Report of Children's Abilities - Revised
What your child can say

Does your child say any words yet? Yes ☐ No ☐ *If no go to Section 5*

Children understand many more words than they can say. Here, we are only interested in the words your child says. Please select all the words you have heard your child say. If your child uses a different pronunciation of a word – e.g., "tend" for pretend, or "duce" for juice – select it anyway.

Please keep in mind that this is only a sample of words; your child may know many other words not on this list. If your child is not yet using any words, please go straight to Section 5.

☐ Baa baa	☐ Cream cracker	☐ Bed	☐ Carry	☐ Last
☐ Meow	☐ Juice	☐ Bedroom	☐ Chase	☐ Tiny
☐ Ouch/ow	☐ Meat	☐ Settee/sofa	☐ Pour	☐ Wet
☐ Uh-oh/oh dear	☐ Milk	☐ Oven/cooker	☐ Finish	☐ After
☐ Woof woof	☐ Peas	☐ Stairs	☐ Fit	☐ Day
☐ Bear	☐ Hat	☐ Flag	☐ Hug/cuddle	☐ Tonight
☐ Bird	☐ Necklace	☐ Rain	☐ Listen	☐ Our
☐ Cat	☐ Shoe	☐ Star	☐ Like	☐ Them
☐ Dog	☐ Sock	☐ Swing	☐ Pretend	☐ This
☐ Duck	☐ Chin	☐ School	☐ Rip/tear	☐ Us
☐ Horse	☐ Ear	☐ Sky	☐ Shake	☐ Where
☐ Aeroplane	☐ Hand	☐ Zoo	☐ Taste	☐ Beside
☐ Boat	☐ Leg	☐ Friend	☐ Gentle	☐ Down
☐ Car	☐ Pillow	☐ Mummy/mum	☐ Think	☐ Under
☐ Ball	☐ Comb	☐ Person	☐ Wish	☐ All
☐ Book	☐ Lamp/torch	☐ Bye/byebye	☐ All gone	☐ Much
☐ Game	☐ Plate	☐ Hi/hello	☐ Cold	☐ Could
☐ Sandwich	☐ Rubbish	☐ No	☐ Fast	☐ Need to
☐ Fish	☐ Tray	☐ Shopping	☐ Happy	☐ Would
☐ Sauce	☐ Towel	☐ Thank you	☐ Hot	☐ If

Section 4: Parent Report of Children's Abilities - Revised
How your child uses words

We would like to know how your child uses or understands words. Please select one answer for each question below.

Keep in mind that these questions are for children up to 4 years of age. Many children of your child's age will not be able to say some of the words or sentences below.

	Not yet	Sometimes	Often
1. Does your child ever talk about past events or people who are not present? For example, a child who saw a carnival last week might later say 'carnival', 'clown', or 'band'.	☐	☐	☐
2. Does your child ever talk about something that is going to happen in the future? E.g. say 'choo-choo' or 'bus' before you leave the house on a trip, or say 'swing' when you are going to the park?	☐	☐	☐
3. Does your child ever talk about objects that are not present? For example, asking about a missing toy not in the room, or asking about someone not present?	☐	☐	☐
4. Does your child understand if you ask for something that is not in the room? For example, would s/he go to the bedroom to get a teddy bear when you say 'Where's the bear?'	☐	☐	☐
5. Does your child know who things belong to? For example, a child might point to mummy's shoe and say 'Mummy'.	☐	☐	☐
6. Has your child started to put together words yet, such as 'Daddy gone' or 'Doggie bite'?	☐	☐	☐

If you answered "Sometimes" or "Often" to Question 6, please answer questions 7-18 below.

For EACH PAIR of sentences below – A and B – please choose the one that sounds MOST like the way your child talks at the moment, even if s/he would not say that EXACT sentence. If your child is saying sentences even more complicated than the two examples provided, please choose B.

7. (Talking about something happening now) A ☐ I make tower B ☐ I making tower	8. (Talking about something that already happened) A ☐ Daddy pick me up B ☐ Daddy picked me up	9. A ☐ That my truck B ☐ That's my truck
10. A ☐ Baby crying B ☐ Baby is crying	11. A ☐ There a doggie B ☐ There's a doggie	12. A ☐ Coffee hot B ☐ That coffee hot
13. A ☐ I no do it B ☐ I can't do it	14. A ☐ I like read stories B ☐ I like to read stories	15. A ☐ Biscuit Mummy B ☐ Biscuit for Mummy
16. A ☐ Don't read book B ☐ Don't want you read that book	17. A ☐ Baby want eat B ☐ Baby want to eat	18. A ☐ Look at me B ☐ Look at me dancing

Section 5: Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of your child's behaviour ***over the last six months***.

	Not true	Somewhat true	Certainly true
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Section 6: Ages and Stages Questionnaires®-3

All children develop at different rates and in different ways. Please do not worry if your child is not doing all or any of the activities mentioned in the questionnaire. It is not a test.
The activities are simply one way of understanding how your child is progressing.

Please complete the Ages and Stages Questionnaires®-3 shown below.

Possible answers:

Yes = your child does this activity (or has done it and has now progressed, e.g. crawling, but is now walking)

Sometimes = your child is just beginning to do this activity (but does not do it regularly)

Not Yet = your child has not yet started doing this

Please leave **blank** any activities your child has not been able to try with you.

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please choose the circle that indicates whether your child is doing the activity regularly (yes), sometimes, or not yet.

Important Points to Remember:

✓ Try each activity with your child before marking a response.

✓ Make completing this questionnaire a game that is fun for you and your child.

✓ Make sure your child is not tired or hungry.

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark “yes” for the item.

GROSS MOTOR

		Yes	Sometimes	Not yet	
1.	Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the handrail or wall. *(You can look for this in a shop, in a playground, or at home.)*	◯	◯	◯	
2.	When you show your child how to kick a large ball, does he try to kick the ball either by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark “yes” for this item.)* 	◯	◯	◯	
3.	Does your child walk either up or down at least two steps by herself? She may hold onto the handrail or wall. 	◯	◯	◯	
4.	Does your child run fairly well, stopping herself without bumping into things or falling over? 	◯	◯	◯	
5.	Does your child jump with both feet leaving the floor at the same time? 	◯	◯	◯	
6.	Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	◯	◯	◯	

FINE MOTOR

	Yes	Sometimes	Not yet	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	◯	◯	◯	
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	◯	◯	◯	
3. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	◯	◯	◯	
4. Does your child flip switches off and on?	◯	◯	◯	
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use cotton reels, small boxes, or toys that are about 1 inch in size.)*	◯	◯	◯	
6. Can your child string small items such as pasta or beads onto a string or shoelace? *(Carefully watch your child's use of beads and strings for safety reasons.)* 	◯	◯	◯	

Section 7: Community health and social care contacts

7.1 Children may come into contact with a number of professionals who are there to help and support you in your daily life. We would be grateful if you could indicate which, if any, your child has seen in the last six months.

Please choose yes or no for each professional listed. ***If choosing yes***, please indicate the number of times your child saw that professional **in the last six months**.

Community Professional	Please choose	Total number of contacts in the last six months
General Practitioner (GP)	Yes ☐ No ☐	
Health Visitor	Yes ☐ No ☐	
Practice Nurse	Yes ☐ No ☐	
Community Nurse	Yes ☐ No ☐	
Community children's doctor (Paediatrician)	Yes ☐ No ☐	
Physiotherapist	Yes ☐ No ☐	
Occupational Therapist	Yes ☐ No ☐	
Speech and Language Therapist	Yes ☐ No ☐	
Orthotist	Yes ☐ No ☐	
Dietitian	Yes ☐ No ☐	
Social Worker	Yes ☐ No ☐	
Early educational support worker (e.g. extra help at nursery for visual or hearing impairments)	Yes ☐ No ☐	
Other (please specify) _____	Yes ☐ No ☐	
Other (please specify) _____	Yes ☐ No ☐	

Personal circumstances and financial costs

7.2 Which of these best describes your current situation? *(Please choose **only one** box in each column. If you are on maternity/paternity leave, please report what you expect your status to be when this leave ends.)*

You	Your partner Not applicable ☐
☐ In paid work full-time	☐ In paid work full-time
☐ In paid work part-time	☐ In paid work part-time
☐ At home looking after my family or dependents	☐ At home looking after my family or dependents
☐ In education	☐ In education
☐ Unemployed	☐ Unemployed
☐ Unable to work because of disability or ill health	☐ Unable to work because of disability or ill health

If you and / or your partner ***are*** in paid employment, ***please continue to Question 7.2.1, otherwise please proceed to Question 7.3.***

7.2.1 **In the last six months, have you and / or your partner needed to take any time off work as a result of your child's health? (Please do not include time when you were on maternity / paternity leave)**

Please choose yes or no for each option. ***If choosing yes***, please provide the number of days taken off work

	You **Not applicable** ☐	**Your partner** **Not applicable** ☐
Have you and/or your partner taken time off work***?*** *If Yes, how many days have you taken off work* ***in the last six months***	Yes ☐ No ☐ Days off work	Yes ☐ No ☐ Days off work

7.3 **In the last six months, have you needed help at home** *(for example with food shopping, preparing meals, cleaning, laundry, the looking after of other children)* **from any other family members or friends as a result of your child's health?**

Please choose Yes or No. Yes ☐ No ☐

If No, *please go to Question 7.4.*

7.3.1 ***If Yes****, please try to estimate for how long in total you received this help* ***over the last six months:***

☐	Less than a month - Please give number of weeks ☐☐
☐	Between one month and three months – Please give number of months ☐☐
☐	Between three months and six months – Please give number of months ☐☐

7.3.2 **Thinking of a typical week when you needed help, on how many days of that week would you have received this help? This may be difficult as every week may be different, but please give a best average or estimate.**

1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐

7.3.3 **On a typical day when you needed help, please try to estimate the average number of hours of help you received. This may be difficult to remember, and may have varied from day to day, so please give your best estimate.** Hours per week ☐☐☐

7.4 **In the last 12 months, have you and/or your partner had any additional personal financial costs because of your child's health?**

Please choose yes or no for each cost listed. ***If choosing yes***, please provide an amount and a description of what you needed to pay for.

Examples of costs to you in the last 12 months	**Please choose**	**If Yes, please give amount spent in the last 12 months**	**Please give details**
Have you purchased special equipment ?	Yes ☐ No ☐		
Have you made changes to your home?	Yes ☐ No ☐		
Other (please specify)? _____ _____	Yes ☐ No ☐		

Section 8: EQ-5D-5L

We are interested in finding out how you are doing in terms of your health today.

Under each heading, please tick the **ONE** box that best describes your health **TODAY.**

8.1 MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

8.2 SELF-CARE

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

8.3 USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

8.4 PAIN / DISCOMFORT

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

8.5 ANXIETY / DEPRESSION

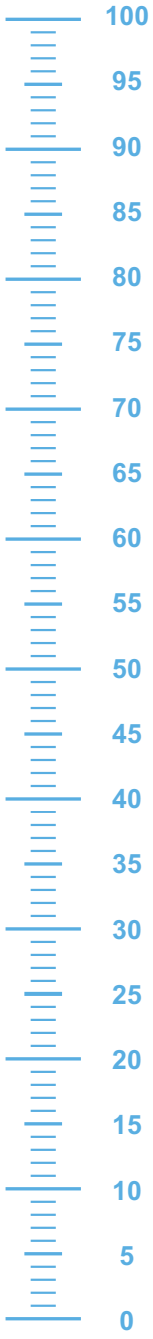
- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

- **We would like to know how good or bad your health is TODAY.**
- **This scale is numbered from 0 to 100.**
- **100 means the best health you can imagine.**

  0 means the worst health you can imagine.
- **Please mark an X on the scale to indicate how your health is TODAY.**
- **Now, write the number you marked on the scale in the box below.**

YOUR HEALTH TODAY = ☐

The best health you can imagine



The worst health you can imagine

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

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