PARENTS‘ QUESTIONNAIRE

FOR INTERNATIONAL PATIENTS

Dear parents, dear care persons,

we thank you for the registration of your child in the kbo-Kinderzentrum München.

Please fill out this questionnaire carefully and attach all examination documents at your disposal (especially all medical reports).
Only then we can plan best possible the treatment in advance.

We thank you for your endeavours!

Please send the questionnaire together with the respective medical reports and former examination results to:

kbo-Kinderzentrum München
Heiglhofstrasse 65
D-81377 Munich, Germany

For any further information we are gladly at your disposal:

Per telephone
under 0049 89-71009-0
or per email under
patientenaufnahme.kiz@kbo.de

We are looking forward to helping you.

Your kbo-Kinderzentrum München

kbo-Kinderzentrum München
gemeinnützige GmbH

Sozialpädiatrisches Zentrum u. Neuropädiatrie
Dr. med. Michael-Andor Marton

- Frühe Entwicklung und Kommunikation
  Dr. med. Margret Ziegler
- Hören · Sprache · Cochleaimplantate
  Dr. med. Katharina Eder
- Sensomotorik
  Dr. med. Maesa Al-Hallak
- Epileptologie · EEG
  Dr. med. Daniela von Pfeil
- Medizinische Genetik
  Dr. (Univ. Verona) Monika Cohen
- SPZ am Standort Schwabing
  Dr. med. Armin Gehrmann

Fachklinik für Sozialpädiatrie und Entwicklungsrehabilitation

Psychologie
Dipl.-Psych. Sabine Herold
Dr. phil. Maria Licata-Dandel

Geschäftsführer
Alexander Lechner

Ärztlicher Direktor
Univ.-Prof. Dr. med. Volker Mall
Lehrstuhlinhaber für Sozialpädiatrie
an der TU München

Pflegedirektorin
Ute Schmitz

KIZ PatVerwFO: ElternFBKinternational engl. /Stand 12.10.2020/ Version 03

Patient's number: _____ (Will be filled in by kbo-Kinderzentrum München)

Details to patient and family

Name of child: Family name: _____ Prename: _____

Sex: ☐m ☐f ☐d Born at: _____ in: _____

Care of: ☐ parents ☐ father ☐ mother ☐ adoptive parents ☐ foster parents ☐ institutional care

street / zipcode / location:

telephone no. reachable during the day: _____ telefax: _____

Main insurer: _____ born at: _____

Insurance number of the child: _____

Name and address of health insurance: _____

Name of father: _____ Prename: _____

Born at, in: _____ code, location _____

Street: _____ tel. / mobile: _____

occupation(learned) _____ telefax: _____

at time practiced: _____ E-Mail: _____

employer (name, if any tel.): _____

Name of mother: _____ Prename: _____

Maiden name: _____

Born at, in: _____ Code, location _____

Street: _____ tel. / mobile: _____

occupation(learned) _____ telefax: _____

at time practiced: _____ E-Mail: _____

employer (name, if any tel.): _____

Care person: ☐ parents ☐ father ☐ mother ☐ _____

If there are other care persons than the above, please mention here name, prename, address, telephone number, occupation and health insurance with address!

Does your child have siblings / half-siblings? ☐ no ☐ yes:

Prename: date of birth:

_____

_____

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Previous diagnoses/ known diseases

☐ cerebral palsy

☐ epilepsy / seizure disorder yes ☐ no ☐

seizures at present?_____/when last?_____

☐ premature birth

☐ trisomy 21

☐ Spina bifida

☐ tumor diseases

☐ neurofibromatosis

☐ developmental retardation speech

☐ hearing loss yes ☐ no ☐ not tested ☐

☐ developmental retardation motoric/ impairment of motor activity

☐ distinct visual disorder (squinting, blindness)

☐ allergies / drug incompatibility, if yes

which?_____

_____

_____

☐ behavior disorder (e. g. frequent crying, excessive anxiety, sleep disorders, eating disorders, extreme calmness or goodness, hyperexcitability etc.)

☐ others:_____

_____

_____

Which examinations were carried out and which are the results?

☐ MRI_____

_____

_____

☐ EEG_____

_____

_____

☐ Sonography/Echocardiography _____

_____

_____

☐ Genetic diagnostics_____

_____

_____

☐ Metabolic examinations_____

_____

_____

☐ Lumbar puncture_____

_____

_____

☐ Others_____

_____

_____

Please attach written medical/examination reports to this registration.

Questions to present disorder or disease

Why do you wish to register your child for an examination at the kbo-Kinderzentrum München?
Which kind of help do you expect from us?

_____
_____
_____
_____

Does the child receive a regular medical care because of this disorder? yes ☐ no ☐

Name, address and telephone number of the last caring doctor:

_____

Has any therapy been started (e.g. physiotherapy, occupational therapy, speech therapy, early intervention, orthopedic aids like abduction pants, splints, ortheses, braces, wheelchair etc.)?

Which?	Since when?
_____	_____
_____	_____

Does your child take any medication? Please note here

_____
_____
_____
_____

Birth

Were there any problems during pregnancy and/or at birth?

_____
_____

Where did birth take place? clinic ☐ at home ☐

Was the child born at the scheduled time? yes ☐ no ☐

In which week of pregnancy? _____

Was any procedure necessary at delivery (forceps, suction cup, Cesarian section)? yes ☐ no ☐

Newborn infant

Birth weight	_____	g	unknown ☐
Birth height	_____	cm	unknown ☐
Head circumference (with U2)	_____	cm	unknown ☐
APGAR-values:			
APGAR-Index after 1 minute	_____		unknown ☐
APGAR-Index after 5 minutes	_____		unknown ☐
APGAR-Index after 10 minutes	_____		unknown ☐
NS-pH	_____		unknown ☐

First days of life of the child

Were there any complications at or after birth? yes ☐ no ☐

Was the child moved to a pediatric hospital after birth or within the first 7 days of life? yes ☐ no ☐

Did any of the following occur during the first 10 days of life?

- jaundice yes ☐ no ☐ unknown ☐
- epileptic seizures yes ☐ no ☐ unknown ☐
- breathing disorders, artificial respiration yes ☐ no ☐ unknown ☐
- newborn infections (sepsis, meningitis) yes ☐ no ☐ unknown ☐
- oxygen deficiency yes ☐ no ☐ unknown ☐
- cerebral bleeding yes ☐ no ☐ unknown ☐
- other diseases yes ☐ no ☐ unknown ☐

  Which? _____

  _____

Milestones of development

turning over	_____months	first free steps	_____months
belly crawling	_____months	first words	_____months
crawling	_____months	no more diapers during day	_____months
free sitting	_____months	no more diapers during night	_____months
pulling up to standing	_____months		

Epilepsy

Does or did your child have epilepsy or epileptic seizures (grand or petit mal)?

unknown ☐ yes ☐ no ☐

Time of first seizure at the age of: _____

Please describe a seizure (position and movement of head, trunk, arms and legs, responsiveness of the child, appearances/symptoms after the seizure):

grand seizures ☐ focal seizures ☐ absences ☐ other ☐

_____

_____

Frequency (daily, weekly, monthly) and duration (seconds, minutes) of the seizures?

_____

_____

_____

Which medication and how much of it does your child take per day against these seizures?

_____

Feeding and eating habits

Was your child breastfed?	yes ☐	no ☐
Were there any problems with breastfeeding/drinking?	yes ☐	no ☐
Was your child fed at any time more than 3 days artificially through the nose (tube feeding)?	yes ☐	no ☐ unknown ☐
Does your child already drink from a cup?	yes ☐	no ☐
Does your child eat independently?	yes ☐	no ☐ partly ☐

Please give an overview about the present feeding of your child (number of meals, kind of food, mashed, tube feeding)

_____

_____

_____

_____

PLEASE FILL OUT THE FOLLOWING PAGE COMPLETELY AND SIGN AT THE MARKED PLACES!

Clarification of (parental) custody

Name, prename, date of birth of the child: _____

Name, prename, date of birth the person having the custody: _____

_____

Address (if different): _____

_____

I/we herewith confirm that I/we as the person(s) having the custody agree that the above-mentioned child will be introduced in the kbo-Kinderzentrum München for diagnostics and therapy. A fosterage or guardianship does not exist and is not applied for at the present.

With my/our signature(s) I/we declare having the custody for the patient and also can legally sign also in the name of any other person having the custody and declare that this person agrees to the registration in the kbo-Kinderzentrum München. I/we will inform the kbo-Kinderzentrum München immediately if any changes regarding the custody will occur.

X_____

Date & personal signature of the person(s) having the custody

HINT: Without your signature an examination of your child in the kbo-Kinderzentrum München is for legal reasons not possible!

If a fosterage or a guardianship exists, please attach the brevet and enter the name of the legal holder of custody:

_____

Declaration of consent acc. to General Data Protection Regulation (EU-GDPR)

I/we herewith agree that personal data, especially name, contact data, health and social data may be ascertained, processed and saved for the purpose of fulfillment of the contract/patient's care. To fulfill the legal stipulations, the kbo will save the data for further 30 years after conclusion of the fulfillment of the contract/patient's care.

Furthermore I agree that after completion of the treatment the pediatrician practice (see page 2) will receive a doctor's letter from the kbo-Kinderzentrum München including all diagnoses (if necessary also genetic diagnoses).

According to Art.15 EU-GDPR I/we have the right at any time to ask kbo for extensive information regarding the saved data. I/we can at any time according to Art.17 EU-GDPR ask for correction, deletion and blocking of personal data.

I/we am/are aware that I/we can at any time without giving any reasons make use of my/our right of objection and change/limit or totally revoke the given declaration of consent with effect for the future.

The revocation has to be sent per post to the following address: Kliniken des Bezirks Oberbayern - Kommunalunternehmen kbo-Konzerndatenschutzbeauftragter ・ Postfach 22 12 61 ・ 80502 München, Germany.

The relevant authority for the kbo is:

Bayerischer Landesbeauftragter für den Datenschutz ・Postfach 22 12 19 ・80502 München
or Wagmüllerstraße 18 ・80538 München, Germany.

X_____

Place, date & personal signature(s) of the person(s) having the custody