Irish National Register for Children with Down Syndrome

Version 4

Name of Child:	Attach Addressograph Label
Contact Number:	
Location: Place/County	Urban ☐ Rural ☐
Reporting Centre:	
Date of Birth: Singleton Birth:	Yes ☐ No ☐ If no please state number: ______________
EDD:	
Gender:	Male ☐ Female ☐
Ethnicity:	
Weight at birth: Length at birth: Conception: Natural ☐ Artificial ☐ Do not wish to discuss ☐	__________ kg __________ cms IVF ☐ IUI ☐ ICSI ☐ Donor ovuam ☐ Donor Sperm ☐ Donor embro ☐
Type of Delivery:	Normal ☐ C-Section ☐ Emergency C- Section ☐ Other______________________________
APGAR Score Resuscitation necessary Yes ☐ No ☐ Special care needed after birth: Yes ☐ No ☐	___________/_____________ at 1 minute ___________/_____________ at 5 minutes Details of Resus: Duration of Special care:
Transferred to a different Hospital Yes ☐ No ☐	Age at Transfer: ____________________ Transferred to: _____________________ Why:
Consultant:	
Paediatrician:	
Parent(s)/guardian(s) name(s): Parents age at delivery:	Mothers name: Mothers DOB: Fathers name: Fathers DOB:
Prenatal Diagnosis: Yes ☐ No ☐	Prenatal maternal blood sampling ☐ Amniocentesis ☐ Chorionic Villus Sampling ☐
Birth order (1st, 2nd. 3rd child etc)	
Family history of Down syndrome:	Yes ☐ No ☐
Karyotype result (if available):	
Vaccine for Respiratory Syncytial Virus (RSV):	Yes ☐ No ☐
Medical Issues at Birth	Yes ☐ No ☐
Method of Feeding	Exclusive Breast ☐ Combined feeding ☐ Bottle ☐ NG Feeds ☐ OG Feeds ☐ Peg ☐ TPN ☐

Please return completed forms with the Register copy of the consent form to: Ms Fiona Mc Grane, Department of Paediatrics, Trinity Centre for Health Sciences, Tallaght Hospital, Dublin 24. Alternatively scan documents and email to fiona.mcgrane@amnch.ie. Many Thanks

Tests carried out: ECG: Yes ☐ No ☐	Date:______________________ Findings: ____
ECHO: Yes ☐ No ☐	Date: _____________________ Findings: ____
Cardiac Abnormality found: Yes ☐ No ☐	Complete Atrioventricular septal defects ☐ Atrial septal defect ☐ Ventricular septal defects ☐ Patent Ductus Arteriosus ☐ Tetralogy of Fallot ☐ Pulmonary Hypertension ☐ Other_____________________________
Intervention Necessary:	Resuscitation at Birth ☐ Details __________________________________ Emergency Transfer ☐ Monitoring of condition ☐ Oxygen Therapy ☐ No treatment necessary ☐
Gastrointestinal Abnormalities: Yes ☐ No ☐	Duodenal Atresia ☐ Imperforate anus ☐ Hirschsprungs disease ☐ Small bowel obstruction ☐ Annular Pancreas ☐ Other: ____
Thyroid Issues: Yes ☐ No ☐ Medication Needed: Yes ☐ No ☐	Hypothyroidism ☐ Hyperthyroidism ☐ Medication:___________________ Dosage: _____________
Ophthalmology screening: Yes ☐ No ☐ Problem(s) identified: Yes ☐ No ☐	Cataracts ☐ Congenital Glaucoma ☐ Retinopathy due to prematurity ☐ Blindness ☐
Audiology Screening: Yes ☐ No ☐ Problem(s) identified: Yes ☐ No ☐	Conductive hearing loss ☐ Sensor neural hearing loss ☐ Failed hearing assessment unknown cause ☐
Respiratory issues: Yes ☐ No ☐	Low oxygen saturations due to cardiac issues ☐ Respiratory issues due to hypotonic ☐ Tracheobronchomalacia ☐ Pulmonary hypoplasia ☐ Tracheo-oesophageal fistula ☐ Subpleural cysts ☐ Other: ____
Haematological Abnormalities	Transient Myeloid Leukaemia Yes ☐ No ☐ Other:____

Form completed by____

Date: ________________________

Register ID (For office use only) _______________________

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