Appendix 2 - ParticiPAte CP Standard Care Record

Cohort

This is a diary for you to record the care that your child receives from other health professionals in the study period. Please complete this diary to the best of your knowledge and memory. It is important for you to record any care, regardless of the type, duration, or intensity. Please complete this diary from the time you had your first assessment until the time you had completely finished participation in the study.

Child ID: _____
Your first assessment was/will be (date):
Your last assessment (study finish) was/will be (date):
You should fill in from week **1 to 16/24**

Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Physiotherapy	0.5								1								1							
Occupational therapy		2										2										2		
Speech/Language Therapy																				3				
Exercise Physiology/Therapy																								
Psychology/ Counselling				1														0.5						

Below, indicate the number of hours (in 0.5 increments, e.g. 30 mins) that **your child** had with each of the following health professionals for **each week** of the study. Leave boxes blank if no therapy of the given type was accessed during that week.

YOUR DIARY

Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Dates:																								
Physiotherapy																								
Occupational therapy																								
Speech/ Language Therapy																								
Exercise Physiology/ Therapy																								
Psychology/ Counselling																								

NOTE: Therapy includes:

- Privately funded therapy
- Publically funded therapy, including though Queensland Health and the Queensland Department of Education and Training
- Therapy provided by a non-government organisation

If you do not know how many hours of therapy your child accessed, but you know they receive a therapy service, please estimate to the best of your ability how many hours you think they may have received.

DID YOUR CHILD RECEIVE ONE OR MORE DURING THE STUDY OF (tick if yes)
☐ **Botulinum Toxin?** Describe date/limb:_____
☐ **Casting/splinting?** Describe date/limb:_____
☐ **Other medical interventions?** Describe:_____

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IF YOU WISH YOU MAY FILL IN THE CONTACT DETAILS FOR YOUR CHILD'S THERAPISTS

We can contact your child's usual therapists to ask what 'style' of therapy they used when treating your child. This can help us better explain the differences between the treatment and control groups, because we know exactly what treatments everyone was getting.

THERAPIST CONTACT DETAILS:

Therapist Organisation	E.G. Education Department (State)					
Therapist Email	E.G. sally.example@therapy.com					
Therapist Phone	E.G. (07) 3000 1111					
Therapist Name	E.G. Sally Example					
Therapist Type	E.G. Occupational Therapist					