INTERGROWTH-21ST

UNIVERSITY OF OXFORD

Postnatal Infant Follow-up Study - 1 year visit

Abnormality Form

FGLS Number	__ __ - __ __ __ __
Paediatric Outpatient Record Number	
Paediatric Hospital Record Number	
Date of birth	D D - M M - Y Y
Date of this visit	D D - M M - Y Y
Was the child part of the Preterm Postnatal Follow-up Study?	yes / no

If the child was diagnosed with a chromosomal and/or congenital abnormality, please complete this form

Abnormalities observed during the 1st year of life

Please provide the location of and detailed information about any abnormality

1. Head	yes / no	6. Neck	yes / no	11. Bladder/Kidney	yes / no
2. Face	yes / no	7. Brain	yes / no	12. Limbs	yes / no
3. Ear	yes / no	8. Spine	yes / no	13. Lungs	yes / no
4. Nose	yes / no	9. Heart	yes / no	14 Genitalia	yes / no
5. Throat	yes / no	10. Gastro-intestinal	yes / no	15. Skin	yes / no

18. Detailed Information:

19. Final diagnosis:

Name of Researcher	
Signature	
Researcher Code	