

**CLIENT:** Amir Kumar  
**TELEPHONE PRE-EVALUATION:** October 24, 2007  
**DATE OF EVALUATION:** November 17, 2007  
**DATE REPORT INITIATED:** December 20, 2007  
**REPORT FINALIZED:** February 8, 2008

Amir Kumar is an Indian male who was 1 year and 3 months of age at the time he was seen for evaluation at his home in Orlando, Florida. Also present and participating in the evaluation are his mother Amani and his father Radi. Amir was referred for a rehabilitation evaluation by his attorney, Randall Dillon. The purpose of this evaluation is to assess the extent to which handicapping conditions impede his ability to live independently, handle all activities of daily living, and to assess the disability's impact on his vocational development status.

### **Demographic Information:**

**Client Name:** Amir Kumar; **Social Security #:** XXX-XX-XXXX; **Address:** 8634 Lakeview Terrace Orlando, FL 32801; **County:** Orange County; **Closest Metro Area:** Orlando; **Phone:** XXX-XXX-XXXX; **Birthdate:** 8/5/06; **Age:** 1.3; **Sex:** Male; **Race:** Indian; **Marital Status:** Single; **Birthplace:** Orlando, FL; **Citizen:** Yes; **Elementary/Secondary Education:** Not applicable; **Bilingual:** Hindi spoken but unsure what he grasps; **Glasses:** No; **Dominant Hand:** Left (possibly); **Height:** Unsure; **Weight (present):** approximately 16 pounds; **Weight (pre-injury):** 5.6 pounds at birth; **Date of Onset:** 8/5/06.

**History:** Amir suffered an hypoxic-ischemic event due to fetal distress prior to birth. Amir was born via emergent C-section at 40 weeks, 3 days gestation. Records indicate that he was depressed, floppy and pale at birth. He was intubated due to low Apgar scores (0, 5 and 5 respectively). Radi indicates, "Amir was intubated and taken to the unit. The intensivist came out and told me he obviously had some brain injury, but they couldn't tell me to what extent at that time. That was Dr. Megan Mead and Dr. Clancy Kingsley." Records indicate that Amir was placed on ventilation. By discharge, he was on room air. He remained in the Orlando Regional Medical Center from 8/5/06 to 8/17/06.

**Loss of Consciousness or Altered State of Consciousness:** Distressed at birth.

**Independent Recall:** No.

**Rehabilitation Program(s) [In/Outpatient Since Injury]:** Amir remained hospitalized at Orlando Regional Medical Center from 8/5/06 to 8/17/06. He was discharged home to the care of his parents.

PT and OT prescriptions were issued by Florida Children's Hospital on 12/4/06. Initial OT, PT & ST evals were done on 12/20/06.

Amir began therapy at Florida Children's Hospital. OT began on 12/20/06 at one time per week for one hour each. He also began PT at the same time, one time per week for one hour. This continued until early July 2007, when the family moved to Orlando, FL.

Amir was also evaluated by ST at Florida Children's Hospital and they were providing feeding therapy. Mom says she was never told that they recommended therapy 1-2 times per week as indicated in the report. He only went a total of maybe 3 or 4 times. She was told to bring him in when needed for feeding therapy. To the best of her recall, they saw the feeding therapist four times. *"Once was because I could not get him to increase his feeds above two ounces at a time and he was always staying hungry. The second was a follow-up four weeks later. Then there was a long delay and a moving x-ray was done to see if he was aspirating. He was not gaining weight. The last time he was seen for reflux, because he was having trouble with commercial or store bought baby food. We changed over to making up his baby food ourselves. This helped. I make up all his food at home and he no longer needs the Prevacid he was receiving. He no longer sees the feeding therapist. I would like to, but I do not have anyone here that specializes in this. I saw a neurologist in the last week and he did not mention any feeding issues or failure to thrive. I mentioned to him the failure to thrive, but he did not express any response to this. This was Dr. Holden. Amir's pediatrician says he is still classified as failing to thrive."*

Orlando Infant Services an Early Intervention program in Orlando provided PT in the home one time per week for one hour. This began sometime in early 2007. Later they added OT one time per week for one hour. This overlapped the PT and OT he received at Florida Children's Hospital. *"We paid 5% of this out of pocket rather than have insurance cover any, so there would be no cut back from insurance on the amount of therapy. We wanted to maximize his therapy support."*

A month ago (September 2007), he began therapy through the Ahead Program in Orlando, FL, covered under Part C, (under IDEA), and provided in the home. OT started in September 2007 at one time per week for one hour, and as of this week (10/22/07) OT has been increased to 2 times per week for one hour each time. ST started a month ago (October 2007), and he has one hour, one time per week. They are trying to get this increased to 2 times per week. They are working on oral motor stimulation, reducing the oral aversion, as well as developing speech. PT started 10/22/07 and he is having 3 sessions per week for 30 minutes each. This is provided at Progressive Pediatric Rehabilitation, Inc. in Lake Mary, FL.

Amir has had one episode of gastroenteritis and approximately four episodes of upper respiratory infection since birth. Only the episode with gastroenteritis required hospitalization so that he could be given IV fluids. He was hospitalized one other time for failure to thrive. In this latter hospitalization, he was observed, evaluated and sent home with a feeding supplement, (ready to feed, 24 calorie per ounce, formula). He still feeds twice in the middle of the night. He awakens hungry and irritable. Mom gets up with him, as does Dad quite often, to provide the feeds. He has to be rocked or patted back to sleep. (We discussed the fact that this has become behavioral and intervention is likely necessary to withdraw these supports.)

**Prior Medical History:** Not applicable.

## Chief Complaint(s)

### Current Disability

**Disabling Problems: (By client/family history and report. No physical examination occurred).**

Radi, *“Cerebral Palsy is his primary diagnosis. He has problems in that he is way behind in his milestones. He is not acting as a normal child would. He cannot sit up. He is fifteen months old and he should be running by now. He cannot hold his neck up correctly. His motor skills are way behind. He can’t walk. He is not even able to say basic words like momma and dada. His fine motor skills are pretty bad, especially with his hands and arms. He has a big problem with supination. I see him having a big problem later on with writing due to his fine motor skills. He has a problem with lateralization, so he cannot do a task with one hand. If he tries to reach for an object, he has to try and use the second hand to assist in some fashion because he can’t make the first hand work to complete the task. The type of CP he has is the mixed type, because he has high tone in the upper extremities and low tone in the neck and trunk muscles. He is unable to crawl and he cannot hold his head up while in a crawl position. Just a month ago, he began recognizing his own name and this is very late. I was very worried about this.”*

Amani, *“Cerebral Palsy, failure to thrive and myoclonus jerks. He is feeding better and beginning to thrive. Myoclonus jerks lasted for about two months, then stopped. With him, my concerns, he is much smaller in size and this is contributing to his failure to being able to control his head. Being underweight is also creating problems with his being able to control his balance and feeling comfortable in various positions. Because of his physical skills, he is not able to carry out playing with any toy properly, so he has not learned to press, bring things to midline and he has not learned to bring his hands to his mouth. He does not grasp properly, so he cannot self-feed. It is*

*harder for me to teach him things because his coordination is poor and he can't learn to copy movements. Also because of his poor muscle tone, his arms are always pronated and his muscles are tighter and he has a kind of a bowing to his legs. This causes him to put more weight to the outside of his feet, which makes him look bow legged. Because he has not learned to sit yet, he has a flattening to the back of his head which distorts his physical appearance. His right side is tighter than the left and his head tilts to the right as a result. Because of his fine motor deficits, he cannot hold his bottle and this creates a continued commitment in time on my part, to his care at a level most mothers do not have. He has a grinding problem with his teeth and has worn down two of his front teeth. (We also discussed mild accumulation in the mouth and its effect on the teeth because he is using a bottle much longer than most children.) He tends to hold his thumbs curled under even when his fingers are held open and extended. He also has oral aversion. It is very hard for me to introduce new textures to him and he will not try anything that is solid without gagging and throwing up. Due to the tightness in his legs, he will not keep his feet flat. When I stand him up, he tends to move up on his feet and he inverts his feet so weight is born on the interior side on both feet. Because of his muscle problems, he can't roll over properly. He will try, but his arm gets stuck behind him and he will try and roll over it, and I worry he will dislocate his shoulder. Because he is not able to do so much, it is harder for him to be self-soothing for very long. He will get bored and cry or seek attention. He is constantly hungry and I go from feed to feed to feed all day long and yet he still does not gain weight. He has a tongue thrust also. Because of his oral aversion, he tends to push everything out of his mouth. When he sleeps, he pulls his arms tight to his chest with his wrist curled under."*

## **Developmental Delay**

### **Seizure Disorder**

**Type:** Not diagnosed with seizures, but he did have myoclonus jerking. The jerking lasted about 2 months and then stopped.

**Breakthrough Seizures:** No longer having jerking.

### **Surgeries**

**Performed:** No surgery.

**Anticipated:** None recommended at this time.

### **Therapy/Education**

**Therapeutic/Educational Programs Since Onset:** See rehab program.

**School Program:** Not age appropriate at this time.

## Daily Care

**Current Attendant and / or Nursing Care:** Mother is a stay at home mom and cares for him. They do have respite care through UCP. She only uses this when she is very tired or she has to do something. They provide this on a sliding pay scale and they pay \$3 per hour. She does not leave him alone with the respite caregivers, she is either in the home with them or they will ride along with her and sit in the car with Amir while she goes in to do her errands. Last month she used about 12 hours. She has only had respite care for a month. She would like her mom to come from India to help her.

**Bowel/Bladder Program:** He does stay constipated. If very constipated, his mother will give him prunes. Bowel and bladder care managed with diapers. Unable to determine at this point if toilet training will be achievable.

**Self-stimulating Behaviors:** None.

## Motor Skills

**Bring Hands to Midline:** He can bring hands to midline, but he has difficulty bringing them to his mouth.

**Grasp (Left/Right):** He can grasp, and mom feels left side is stronger. He does have problems letting things go from his left hand and problems holding things in his right. He usually will drop things when trying to transfer from one hand to the other.

**Grasp with thumb & forefinger:** No.

**Voluntary purposeful movements (upper & lower extremities):** Yes. He loves to kick with his legs.

**Sit unassisted:** No.

**Hold head erect:** He has recently begun to hold his head up, but it is still difficult for him to hold his head up for more than a few minutes.

**Roll Front to back:** Yes, but not in a normal fashion.

**Roll Back to front:** Yes.

**Pull self upright:** Nonfunctional.

**Drink from cup:** Yes, with assistance.

**Drink from bottle:** Yes, but he cannot hold it independently.

**Tube feeding schedule:** Was discussed but has not been necessary.

**Ambulate:** No.

**Assist in dressing:** No.

**Perform household chores:** No.

**Perform personal hygiene:** No.

**Crawl:** No

**Ascend/descend stairs:** No.

### **Social Skills**

**Smile:** Yes.

**Laugh out loud:** Yes.

**Distinguish family from strangers:** Yes.

**Demand personal attention:** Yes, he will cry and yell.

### **Cognitive Skills**

**Imitate sounds:** Does not imitate sounds, but he will imitate if they click their tongue at him.

**Talk in 1 or 2 word sentences:** No.

**Follow simple 1 or 2 step instructions:** No.

**Avoid hazards:** No.

**Communicate wants and/or needs:** Only by crying.

**Attention to task:** No.

### **Long -Term Care Options**

**Facility/ Home Care:** Home care.

**Anticipated Treatments:** Botox has been mentioned for his muscles. Therapists recommend wheelchairs and feeding chairs. Amir was referred to a Ph.D. in physical therapy. Dr. Holden indicated that this PT would make

the recommendation for the botox. The neurologist will give the injections, but he wants advice from the PT. (PT is Tammi Nona DPT).

## **Psychosocial Issues**

**Patient:** He is not as fussy as he was. He does increase his “*fussy*” behavior when she takes him to physical therapy. He likes to be held and rocked. He wants to be held all the time. (He is going to need behavioral intervention.)

**Family, Emotional Impact on Spouse/Children:** Amani says that she and her husband are doing “*pretty good*”. She has signed up for a support group, Parent to Parent, but she has not started as yet. This group connects parents of children with CP together.

## **Physical Limitations**

**Loss of Tactile Sensation:** Sensation appears to be intact according to Mom. He likes to be tickled and cries if he gets a shot.

**Reach:** He is able to reach with his arms, but he does not do so consistently. The muscles in his arms are very tight. He will reach for an overhead toy. He has trouble bringing things to his mouth.

**Lift:** Not age appropriate ability to lift.

**Prehensile/Grip:** He will grab a toy, but he cannot hold things for more than brief moments. He also cannot grasp a toy in each hand at the same time. He can only grasp and hold a toy in one hand at a time. He will usually drop things when trying to transfer from hand to hand.

**Sitting:** He can only sit when he is supported by someone holding him. Even with propping, he will fall over to his side.

**Standing:** He will weight bear on his legs if held in a standing position. He does not have a stander.

**Walking/Gait:** He will take steps when held in a standing position.

**Bend/Twist:** Nonfunctional.

**Kneel:** Nonfunctional.

**Stoop/Squat:** Nonfunctional.

**Climb:** Nonfunctional.

**Balance:** Poor.

**Breathing:** No dyspnea.

**Headaches:** Undetermined.

**Vision:** Intact. He has had vision testing twice and he should have follow-up with a doctor soon. Parents had concerns about strabismus and he will be seeing an ophthalmologist for follow-up as soon as their insurance is in effect.

**Hearing:** Intact. Tested twice.

**Driving:** Not a likely candidate.

**Physical Stamina (average daily need for rest or reclining):** He tires easily and will show fatigue after therapy, but it is difficult to get him to take a nap.

## Environmental Influences

**Problems on exposure to:**

**Air Conditioning:** No.

**Heat:** Yes, his normal body temperature runs somewhat on the warm side. He sweats easily.

**Cold:** Yes, seems to chill easily.

**Wet/Humid:** No.

**Sudden Changes:** No.

**Fumes:** No.

**Noise:** Yes, becomes irritable in loud environments.

**Stress:** Yes, becomes stressed at PT.

## Present Medical Treatment

<b>Doctors</b>	<b>Specialty</b>	<b>Phone</b>	<b>Fax</b>	<b>Frequency</b>	<b>Last Seen</b>
Nasir Samir, M.D. Orlando, FL	Pediatrician	XXX- XXX- XXXX	XXX-XXX- XXXX	3 X / year	11/6/07
Dr. Holden	Neurologist	XXX-XXX- XXXX	XXX-XXX- XXXX	1 X / 3 months	11/12/07
Child Neurology Center in Orlando, FL					
<b>Therapist</b>	<b>Therapy</b>	<b>Phone</b>	<b>Facility</b>	<b>Frequency</b>	
Cosette	PT	XXX-XXX-	Progressiv	3 X / week	



Mysta		XXXX	e Pediatric Rehabilitat ion, Inc	
Dawn Jerrica	PT	XXX-XXX- XXXX		
Ellie Holder	OT	At home	Therapy Works of Orlando	2 X / week
McKenzie Pru	ST	At home	Central Florida Speech Therapy	1 hr/week

Medication	Strength	Frequency	Tablets	Purpose
Prevacid	15mg	as needed	30	Reflux

**Over-the-Counter Medication(s):** Tylenol, Motrin as needed.

**Drugstore and Phone Number:** Publix in Orlando.

**Assistive Devices:** Bumbo Chair \$45.00, Bumbo Tray \$10.00

Arm splints provided by therapist. He needs a wheelchair.

## Medical Summary

**Date of Medical Summary: 10/15/07**

Amir Kumar is a 1.3-year-old male who suffered hypoxic-ischemic event at birth due to fetal distress.

**ORLANDO REGIONAL MEDICAL CENTER: 8/5/06 – 8/17/06; 11/29/06 – 11/30/06; 5/24/07 – 5/25/07**

**Orlando Regional Medical Center: 8/5/06 – 8/17/06**

Amir was born via emergent Cesarean section for fetal distress at 40 weeks, 3/days gestation. Apgar scores were 0, 5 and 5 at one, five and ten minutes respectively. At delivery, he was depressed, floppy and pale. Treatment at delivery included stimulation, oxygen, bag and mask ventilation and endotracheal tube ventilation. Hospital course was as follows:

**Respiratory Depression:** Amir was intubated due to low Apgar scores. He was placed on ventilation. He self-extubated to nasal cannula on 8/5/06. He developed right-sided atelectasis and chest percussion therapy was provided. At time of discharge, he was stable on room air.

**Apnea:** Amir had episodes of apnea requiring tactile stimulation. These episodes were not related to feeds and last one was on 8/9/06. He had rare self-corrected bradycardia since.

Sepsis: Amir was treated for sepsis with Ampicillin and Cefotaxime. Blood culture was negative and antibiotic therapy was discontinued.

Moderate hypoxic-ischemic brain injury: Pediatric neurology was consulted on 8/5/06. Neurological examination was abnormal. EEG was performed on 8/5/06 and was markedly abnormal due to suppressed background consistent with a global encephalopathy. Amir began to have severe irritability and Lorazepam was prescribed as needed. No seizures were noted. CT scan on 8/7/06 was unremarkable. MRI on 8/8/07 showed ischemic injury to thalamus. At time of discharge, examination remained abnormal but was improving.

Poor Oral Feeding: Amir fed poorly, which was felt to be due to moderate hypoxic ischemic encephalopathy. No gag reflex was noted on examination. Suck mildly improved during admission.

Last intracranial study on 8/9/06 showed bilaterally symmetric hypoxic ischemic encephalopathy involving both thalami, the putamen and both basal ganglia. There was also subinsular involvement on the left. At time of discharge, Amir was less irritable, cortical thumbing was less notable, opened hand spontaneously, had noted gag reflex, and had improved suck reflex and muscle tone. He was discharged to home. Discharge diagnoses:

- 12 day old 40 week AGA (adjusted gestation age) newborn
- Respiratory depression
- Apnea
- Hypoperfusion
- Dysrhythmia
- Sepsis, clinical (early onset)
- Possible mastitis
- Moderate hypoxic-ischemic brain injury
- Poor oral feeding
- Nutritional support

**Orlando Regional Medical Center: 11/29/06 – 11/30/06**

Admitted for failure to thrive. Nutrition consult was obtained and failure to thrive was felt to likely be due to Amir not consuming adequate calories. Similac 24 k Cal formula with minimum of 80-85cc every three hours recommended. Mother advised to return with Amir if he is unable to tolerate the formula. Discharged to home.

**Orlando Regional Medical Center: 5/24/07 – 5/25/07**

Mother presented with Amir with complaint of two-day history of cough, runny nose and one-day history of diarrhea, emesis and fever. They had just returned from a two-month stay in India. Amir was not eating well at all. He was admitted with diagnosis of dehydration, acute gastroenteritis and upper respiratory infection. Nutrition consult was obtained and Amir was below the 3<sup>rd</sup> percentile for height, weight and head circumference.

Dehydration improved and fever resolved. Amir was discharged to home. Mother was instructed to provide 102 K Cal/kg per day. Close follow up as outpatient also recommended.

**FLORIDA CHILDREN'S HOSPITAL: OUTPATIENT 11/28/06 – 2/14/07;  
OT 12/20/06 – 6/19/07; PT 12/20/06 – 8/2/07; ST 12/20/06 – 4/11/07**

**Florida Children's Hospital: 11/28/06**

Outpatient clinic visit for complaint of increased crying, irritability and decreased appetite. Amir was admitted to hospital for diagnosis of failure to thrive.

**Florida Children's Hospital: 12/4/06**

Follow up S/P recent hospitalization for failure to thrive. Fussiness was decreased but there was positive back arching. Zantac prescribed for possible gastroesophageal reflux. Prescriptions for PT and OT issued.

**Florida Children's Hospital: 12/11/06**

Amir was taking 22 ounces daily. He was still fussy and had some back arching. He was not sleeping well during the day and slept poorly at night. He had possible hearing deficit as mother reported Amir did not respond to loud noises and often does not respond to voices.

Zantac was discontinued and Prevacid was prescribed. Referrals issued for ST, OT and PT. Repeat hearing screen recommended. Formula intake increased to 26 k Cal.

**Florida Children's Hospital: 1/2/07**

Amir was jerking during the daytime. He had back arching lasting a couple of seconds. He has failure to thrive, gastroesophageal reflux, spastic quadriplegia, developmental delay in all domains, was slow feeder and had questionable aspiration of thin liquids. Prevacid and therapy continued. Modified barium swallow ordered. Diagnosed with cerebral palsy. Plan was to get notes from feeding team and neurology.

**Florida Children's Hospital: 1/16/07**

Feeding team evaluated Amir on morning of presentation. He had possible aspiration and was scheduled for Barium swallow on 1/18/07. Need for G-tube and Nissen fundoplication discussed.

**Florida Children's Hospital: 1/23/07**

Modified barium swallow was normal. Nipple was changed. Amir was less irritable. He was receiving PT/OT/ST weekly. He smiled, laughed and met midline. He was taking 24g to 27 cal/day.

**Florida Children's Hospital: 2/6/07**

Amir now had splints for hips. He was taking 2-3 hour naps and slept 6 hours straight last night. He reached, smiled, held head up without support and reached for toys. He had hypertonicity and some palmar grasp. He was

switched to 24k Cal formula for he now needed 35-40 ounces to get current calorie intake on 27 k Cal formula. Prevacid and therapy continued.

**Florida Children's Hospital: 2/14/07**

Amir was finishing four ounces of formula in 10-15 minutes. He was now sleeping through the night. He had not yet had pediatric neuro visit. He was receiving therapy 2X/week. Hands were open. Diagnosis: spastic quadriplegia and slow but constant weight gain/head circumference.

**Florida Children's Hospital: OT 12/20/06 – 6/19/07**

Amir participated in OT. On initial evaluation, the Alberta Infant Motor Scale (AIMS) was administered. Amir's motor skills were in the less than 5 percentile for his age. In supine, he presented with an asymmetrical tonic neck reflex and demonstrated no reaching or midline orientation. He had increased difficulty with prone positioning secondary to flexion bias. He presented with significant limitation in shoulder flexion with less than 45 degrees, which caused his chin tuck. Deficits continued in the sidelying position with increased flexion and retraction of the UE's and no reading (?) or midline orientation. When objects were placed in his hands, no grasping reflex was noted. Amir's ROM was limited secondary to hypertonia. He was able to visually track objects in all planes, however, there was no disassociation of eyes from head movement. Amir demonstrated some vocal exploration with cooing, however, parent reported he had been very fussy. Additional concerns included poor feeding skills and resulting failure to thrive diagnosis. OT was recommended once weekly.

Last treatment note dated 6/19/07 indicated mother was concerned that Amir was gagging with textured foods and that he was not gaining weight. He was just diagnosed yesterday by Dr. Cullen with cerebral palsy. Mother reported current diet consisted of 26-30 ounces of Similac Advance (24 cal) every day. Feedings were every 3 hours. Amir was eating at least 5 ounces of formula per feeding. In addition, he was eating homemade puree of cream of wheat, sugar batter, water, wheat cereal, Stage 2 sweet potatoes and mashed bananas. He was recently introduced to Gerber puffs (dissolvable solids). He was no longer waking at night to feed. He continued to require trunk and head support for feeding. He needed total assist to hold a bottle. He took puree via spoon. He was independent with closure on spoon. There was zero tongue lateralization and tongue was noted to be tucked back. He managed a Gerber puff without gagging/choking and using lip closure, tongue protrusion to manage material. Discussion was held with mom about providing a meal schedule with three meals of puree in addition to bottle feeding to increase hunger cycle and age appropriate diet. Continued OT 1X/weekly recommended.

**Florida Children's Hospital: PT 12/20/06 – 8/2/07**

Amir participated in PT. On initial evaluation on 12/20/06, he presented with mild torticollis sustaining about a 10-15 degree right lateral tilt. There was limited active rotation to the right at approximately 75 degrees. Therapist was concerned about premature closing of sutures. CT or x-ray

recommended secondary to possible premature closing of the skull. Amir also exhibited coronal ridging. He had increased tone in upper and lower extremities, which was limiting function. He was restricted in bilateral scapular area and unable to get shoulders to 90 degrees. During evaluation, Amir kept hands tightly fistled and no reaching or grasping of object was noted, as well as no hands to midline. Poor tolerance for prone was noted. In prone position, upper and lower extremities remained flexed with no head elevation. He was unable to flex shoulders to 90 degrees. When a towel was placed under his chest to elevate upper body, he was able to elevate his head to approximately 25 degrees briefly. Poor head control was noted in supported sitting and standing position. Gross motor skills were assessed using the Alberta Infant Motor Scale (AIMS). Amir scored below the 5<sup>th</sup> percentile for age. Outpatient PT recommended 1X/week.

Progress note dated 6/6/07 indicated Amir continued to be significantly limited in ROM in hamstrings, biceps, pectorals and pronators. He was unable to sit independently. He was unable to ring sit, as he kept his LE's stiff and extended with rounded back. He was unable to roll supine to prone, but did roll prone to supine with poor recruitment. He did demonstrate increased ability to reach for toys in supine and prone with UE pronated. He was unable to supinate UE's and hand remained fistled. In prone, he was unable to independently get shoulder to 90 degrees without assist from therapist. With small bolster placed under his chest to assist with prone, Amir was unable to sustain head lift to 45 degrees for more than 2-3 seconds and had preference for right lateral flexion and left rotation.

Last attended PT session was on 7/19/07. Amir was officially discharged from therapy on 8/2/07 due to family moving out of state.

**Florida Children's Hospital: ST 12/20/06 – 4/11/07**

Amir participated in ST. On initial evaluation on 12/20/06, oral motor evaluation was performed. He demonstrated high tone in his tongue, which remained bunched upon contact with a spoon, nipple or finger. His tongue was stimulated to move laterally to both sides but resisted pressure on the center of his tongue with a gloved finger. He demonstrated refusal behaviors when offered bottle. His mom reported he exhibited this behavior at home as well. When offered Stage I puree via maroon spoon, Amir demonstrated anterior/posterior movement of the tongue with a bunched tongue pushing out much of the puree every spoonful. Mother reported she had to force feed him at times which was defined as giving him the bottle even during refusal behavior or crying. Amir was taking about 21 ounces of formula/day, but would take 26-27 ounces on a good day. When given Prevacid in AM, feeding went better throughout the day. He was known to show signs of reflux. He had difficulty with lip seal and rhythmic easy sucking on his bottle. However, at night, he was more drowsy and it appeared to go a little easier.

Recommendations included increasing hunger cycle by increasing the time between feeding to every 2-2 ½ hours in hope of increasing his appetite for each feeding. The concern remained that his outgoing reflux is creating

refusal behavior for feeding as he bore discomfort with the feeding experience. ST recommended 1-2X/week.

Last treatment note dated 4/11/07 indicates that Amir was up to 4+ ounces every 3 hours until 2 weeks earlier when he was switched to powder formula and feedings decreased to ½ to 1 ounce every hour. He had weight loss. Feedings were switched to powder as family was preparing for 3-month trip to India. Therapist reviewed strategies to progress back to every 3-4 hour schedule to promote hunger cycle and increase volume. Continued therapy upon return from trip recommended at frequency of one time weekly.

**CULLEN, ROGER M.D.: 12/6/06 – 1/25/07**

**Cullen, Roger M.D.: 12/6/06**

Neurological follow up S/P hospital discharge. Amir was born at term with hypoxic ischemic encephalopathy as a result of placental abruption. They presented now due to some feeding and weight difficulties and failure to thrive. Amir has also been fairly irritable. He would wake at 3 AM and be inconsolable. There were other times when he would cry incessantly. He was behind in his development. He was not reaching for objects. He was having problems with head control, and they noticed some increased tone.

On examination, Amir had a fair amount of spasticity with increased tone in all four extremities, as well as fisting of his hands. He had brisk reflexes with crossing of his adductors, although examiner could not elicit any clonus.

Amir was showing evidence of motor control problems with increased tone. It was felt his irritability was showing now clinical evidence of a static encephalopathy. They had already been evaluated and were in the process of getting evaluated by Orlando Infant Services and examiner wanted to see how he did in therapy for a little while. There was not a lot to offer in terms of managing the irritability. Benadryl was what they were using and that was fine as long as it was working.

**Cullen, Roger M.D.: 1/11/07**

Amir was worked in urgently for EEG. For the last couple of weeks, he had been having episodes where he would jerk. Initially, parents thought it was hiccups, and mom stated that is really what it looks like but it looks different than when he typically has hiccups. It will recur repetitively at about one minute intervals. It did not happen when sleeping or when he was particularly drowsy. EEG was performed and did not show any evidence of seizure.

Examiner was concerned that Amir might be having infantile spasms. Repeat EEG in two weeks ordered. It did not sound like myoclonus.

**Cullen, Roger M.D.: 1/25/07**

Repeat EEG was within normal limits of variability and did not show any evidence of seizure activity. Amir continued to have episodes of jerking. It

was happening when quiet or often times when he was taking a bottle. It was worse on right than left.

Examiner felt Amir was having some simple myoclonus. It was not felt to be ictal in nature since EEG did not show any evidence of that twice. No treatment was rendered or recommended. Amir had gained some weight so plan was to hold off on feeding tube for now. Follow up in two months recommended.

### **Records Reviewed:**

Florida Children's Hospital: Outpatient: 11/28/06 – 2/14/07;  
 OT 12/20/06 – 6/19/07; PT 12/20/06 – 8/2/07; ST 12/20/06 – 4/11/07  
 Cullen, Roger M.D.: 12/6/06 – 1/25/07  
 Orlando Regional Medical Center: 8/5/06 – 8/17/06; 11/29/06 – 11/30/06;  
 5/24/07 – 5/25/07

### **MEDICAL SUMMARY ADDENDUM: 10/18/07**

#### **PROGRESSIVE PEDIATRIC REHABILITATION, INC: 10/2/07**

PT evaluation. Chronological age 1.2 years. Parents indicated that Amir had cerebral palsy, but they had not been told what type, severity or prognosis. Amir was receiving OT 1X/week and ST 1X/week at home.

Amir had fluctuating tone in general, decreased strength, decreased endurance and postural alignment. He was able to sit with support and hold his head in midline 50% of the time. He could roll in all directions, but could not scoot. He did not maintain prone propping on elbow, but immediately rolled to supine. He could reach for toys in sidelying, better with his right and transferred to his left. He did not bear weight on his LE's in supported 4 point, kneeling or standing. He had a 45" head lag in pull to sit. He exhibited an immature stepping reflex and took steps when held up in standing and leaned forward.

Amir presented with decreased tone in his neck and trunk and increased/fluctuating tone in his extremities, left greater than right. He was able to move around by rolling, but did not scoot, sit or maintain prone propping. He could grasp toys and transfer from one hand to the other. He was alert and cooperative. Problem list included:

- Poor head control-low tone, delayed righting and equilibrium reactions.
- Poor trunk control-low tone, delayed righting and equilibrium reactions.
- Fluctuating tone in extremities.
- Limitations in hip extension and hamstring ROM.
- Gross motor delay to 4-6 month level-cannot sit, crawl or pull to stand.
- Decreased weight bearing on LE's.

PT recommended 3X/week for 45 minutes for period of 6 months. Home exercise program instruction also recommended.

**Records Reviewed:**

Progressive Pediatric Rehabilitation, Inc: 10/2/07

**MEDICAL SUMMARY ADDENDUM: 11/12/07****ORLANDO INFANT SERVICES: 1/5/07**

(Bonnie Booth, Ed.D, PT/Anthony Romeo, M.Ed) Evaluation and assessment to determine eligibility for Orlando Infant Services program services: Assessment tools: Observation, Peabody Developmental Motor Scale 2 (PDMS-2) and Infant-Toddler Developmental Assessment. Chronological age was 5 months.

Amir was not yet playing with toys. When rattle was placed in hand, he did not play or shake it independently. He inconsistently tracked or looked for specific noises in his environment. He did visually track an object (rattle) when moved in an arc from left to right and back (lying on back). He did not attend to a ball that was rolled from one side to the other (Amir held in supported sitting).

Amir was aware of examiners. He smiled while being held. He would seek out mom's familiar face. Mother indicated he was an irritable child, but he was calm during the full examination time. He made a few amorphous babbling sounds. His mother said he could be fussy and vocal. Children this age can usually vocalize five or more consonant and vowel sounds. Amir was not participating in daily care activities. Typically developing children at 5 months would be holding their own bottle.

Amir could lift head in prone for 3 seconds when placed and arms held in close and shoulders stabilized. He could roll from sidelying to back. He could stabilize head when bounced in supported vertical position. He did not have head/neck control in pull-to-sit or supported sitting. He must be supported fully in sitting at this time; however, with stabilization at the shoulders and tactile stimulation on upper back, he could lift head and maintain head position for a brief period of time. Typically developing children at 5 months can maintain head control throughout the full pull-to-sit maneuver, can sit in a forward propping position when placed and have good head control when tilted side-to-side.

Amir could bring fist to mouth, but not reach out for toys. Active movement was limited to stereotypical movements of internal rotation of shoulder with pronation of forearm when rest of arm was extended. Legs were not kicking with the rhythm and briskness of a typically developing child. At five months, typically developing children will prop on forearms in prone and elevate head and trunk 45 degrees, moving arms and legs in fluid movements, beginning to raise legs and play with feet or put them in mouth.



Amir could hold a rattle when placed in his hand. He did not actively reach out, open hand and grasp objects of interest. Mom reported that he had started to reach and touch toys that were on his car seat. Typically developing children at 5 months will be able to reach and grasp a cube presented to them, secure a paper and wrinkle it, pull a string to acquire a toy.

Amir could track an object across his visual field when he was on his back and attention was on task. Typically developing children at 5 months can track objects that cross their visual field when they are in any position. They can play with their fingers in midline and can consistently reach out for toys within arms length.

Amir could bear partial weight through legs in supported standing and still retain the stepping reflex. Typically developing children at five months no longer have the stepping reflex and are beginning to bear full weight-bearing through legs with less support.

Motor abilities and coordination were limited by his high tone in upper and lower extremities and his lack of control (low tone) of head, neck and trunk. Active ROM was limited by high tone (more in UE's than LE's). Passive ranges were good; however, the stiffness put Amir at risk for contractures. For the past two weeks, Amir had begun to exhibit slight body twitches every few minutes. This phenomenon needed to be addressed by a neurologist.

The Peabody Developmental Motor Scales 2 (PDMS-2) results were:

<u>PDMS Domain</u>	<u>Score</u>	<u>%</u>	<u>Age Equiv.</u>	<u>Rating</u>
Gross motor Quotient	76	5		Poor
Reflexes	3	25	3 Months	Average
Stationary	9	5	1 Month	Poor
Locomotion	6	9	1 Month	Below Aver.
Fine Motor Quotient	79	8		Poor
Grasping	6	9	1 Month	Below Aver.
Visual-Motor	8	16	2 Months	Below Aver.

**Records Reviewed:**

Orlando Infant Services: 1/5/07

**MEDICAL SUMMARY ADDENDUM: 11/26/07**

**ORLANDO REGIONAL MEDICAL CENTER: 1/18/07; 2/27/07**

**Orlando Regional Medical Center: 1/18/07**

Barium swallow revealed no evidence of swallowing abnormality or aspiration.

**Orlando Regional Medical Center: 2/27/07**

X-ray of the skull demonstrated suspect mild macrocrania.

X-rays of the facial bones demonstrated normal and symmetric appearance. There was suggestion of some degree of craniofacial disproportion with possible macrocrania. There was no evidence of unusual calcification, bone destruction or other acute process.

**FLORIDA CHILDREN'S HOSPITAL/OUTPATIENT: 2/21/07; 5/24/07; 6/7/07**

**Florida Children's Hospital: 2/21/07**

Treated for diaper rash and upper respiratory infection. Other diagnoses included reflux, hypertonicity, hypoxic ischemic encephalopathy, weight loss and closed anterior fontanelle. Prevacid continued, formula increased and skull x-ray ordered to evaluate for craniosynostosis.

**Florida Children's Hospital: 5/24/07**

Treated for diarrhea and upper respiratory infection.

**Florida Children's Hospital: 6/7/07**

Ten month check up. Since discharge from hospital, Amir was doing much better and was eating better. He was treated for papular rash. He had mixed developmental delay/cerebral palsy due to hypoxic ischemic event. Return appointment recommended in one year.

**BOSWELL, RICHARD M.D.: 3/6/07**

Consultation for strabismus. Amir was 7-month-old who was noted to have an inward-turning left eye for past couple months. On examination, visual acuity was equal and normal. There was a wide nasal bridge giving the appearance of pseudoesotropia. However, examiner saw no evidence of true strabismus either pre or post dilation. Cycloplegic refraction showed moderate myopic astigmatism. The rest of the complete dilated ocular examination was unremarkable. Impression:

- Pseudoesotropia
- Possible intermittent esotropia by history
- Myopic astigmatism

Discussion was held with parents. While possibility of an intermittent esotropia noted at home with convergence stimulus could not be ruled out, examiner thought Amir looked good on examination. Plan was to observe and follow up in six months.

**CULLEN, ROGER M.D.: 6/18/07**

Neurology follow up. Amir was worked in urgently to evaluate for possible Botox. His therapist was concerned because of poor head control and truncal tone with increased appendicular tone with forearms pronated and hands fisted. He also had decreased ROM in hamstrings, biceps, pectoralis, and supinators.

Amir was functioning at about a 3-4 month age level in terms of gross motor skills. He was unable to sit independently. He could not roll from supine to prone. He was reaching for objects, but when he did, he activated both arms at the same time. The myoclonus had resolved. He had not had any other episodes to suggest seizure. He went with mother to India. Over there, he received therapy twice a day on a regular basis. Physicians over there mentioned cerebral palsy to mother.

On examination, Amir had significant truncal hypotonia with head lag and poor posture with slumping when placed upright. He had increased tone in his extremities. Examiner could range him through full ROM, but there was obvious spasticity in his hamstrings, adductors, biceps, pronators and finger flexors. When he activated to reach for object, he extended both arms pronated and fisted his hands. There were 1-2 beats of clonus at the ankles.

Amir was clearly evolving into a spastic quadriplegia pattern, which was explained to parents, was a form of cerebral palsy. At this point, there was significant spasticity, but examiner was not sure it was to the point of warranting and justifying Botox. Examiner could get him through full ROM, and while he agreed that decreasing spasticity might help in terms of his functional mobility, he was a little hesitant to do Botox at Amir's young age, without a more compelling indication, for fear of chronic denervation.

What they were seeing in his UE's, looked like dystonia. That again was part of his static encephalopathy and spastic quadriplegia. Unfortunately, dystonia was not necessarily going to be amenable to Botox either.

### **Records Reviewed:**

Florida Children's Hospital: 2/21/07; 5/24/07; 6/7/07

Boswell, Richard M.D.: 3/6/07

Cullen, Roger M.D.: 6/18/07

Orlando Regional Medical Center: 1/18/07; 2/27/07

### **MEDICAL SUMMARY ADDENDUM: 1/30/08**

### **THERAPY WORKS OF ORLANDO: 9/4/07 - 1/24/08**

#### **Therapy Works of Orlando: 9/4/07**

OT pediatric evaluation. Amir was a pleasant 13-month old male who presented with overall global developmental delay. According to the Mullen, he presented with fine motor skills at 3 months of age. He was able to grasp a toy with palmar grasp, transfer hand to hand, and bang on tray of Bumbo chair. He demonstrated increased reach with left UE, but would use right UE when facilitated. He presented with hypertonicity throughout bilateral UE and trunk, greater on the right side. He appeared happy and motivated to engage with toys and smiled to therapist voice and face. OT was recommended for 60 minutes per week for duration of 6 months. Re-evaluation would be done in March 2008.

**Therapy Works of Orlando: 10/1/07**

OT requested therapy be increased to two times per week to facilitate UE use and parent education.

**Therapy Works of Orlando: 10/4/07**

OT approved for two times per week.

**Therapy Works of Orlando: 11/21/07**

Amir continued with UE limitations, which impaired his ADLs and play.

**Therapy Works of Orlando: 12/7/07**

Amir had made minimal progress with UE use to transition into sitting. Maximum assistance was still needed. He would benefit from supination straps. He was to get new resting hand splints.

**Therapy Works of Orlando: 12/20/07**

Amir continued with poor trunk control, inability to transition and sustain positions.

**Therapy Works of Orlando: 12/22/07**

Amir was progressing with self-feeding.

**Therapy Works of Orlando: 12/28/07**

Amir was progressing with upper extremity goals and ADL's.

**Therapy Works of Orlando: 1/10/08**

Amir was holding items in each hand for up to 20 seconds now. He improved overall.

**Therapy Works of Orlando: 1/11/08**

Ability to bring hands to mouth for self-feeding was improved.

**Therapy Works of Orlando: 1/18/08**

Discussed with Mom trying some augmentative communication using pictures and following his ability to choose between 2 items and control visual gaze.

**Therapy Works of Orlando: 1/24/08**

Passive ROM in bilateral upper extremities continued to be within normal limits. Amir was progressing with upper extremity use and self-feeding.

**HOLDEN, NIGEL, M.D.: 11/12/07**

Amir was seen for neurological assessment. He had spastic quadriplegia felt secondary to hypoxic ischemic encephalopathy. His MRI showed bilaterally symmetric lesions in the thalami, putamen and basal ganglia consistent with hypoxic ischemic encephalopathy with subinsular involvement on the left. Impression: Developmental disorder of unclear etiology. Interventions

needed to maximize his potential were discussed with parents. He was to continue therapies. Microarray and PT evaluation ordered.

**Records Reviewed:**

Therapy Works of Orlando: 9/4/07 - 1/24/08

Holden, Nigel, M.D.: 11/12/07

**MEDICAL SUMMARY ADDENDUM: 2/5/08**

**NEWMAN, BROCK M.D.: 1/2/08**

Ophthalmology evaluation. Mother was concerned about right eye crossing for past 3-4 months. Diagnosis: Early myopic astigmatism.

**PROGRESSIVE PEDIATRIC REHABILITATION, INC: 1/25/08**

Amir was 18 months of age. He had made excellent, steady progress in PT. He was pleasant, cooperative, very bright and motivated. He enjoyed watching other children playing and was also reaching for and playing with toys. Parents were very invested and very good at following through with home exercise program.

Head control was improved in all positions and Amir was beginning to maintain his head at 90 degrees in prone propping on elbows and extended arms. He continued to fist for UE weight bearing, but could bear weight on open hands and weight shift to reach for toy with moderate facilitation 3/5 times. He could also bear weight on open hands with UE's extended and on knees and rock with moderate facilitation for up to 30 seconds.

Without facilitation, his sitting was marked by posterior pelvic tilt and he could not maintain independent sitting in any position. In pull to sit, Amir only showed 30 degrees head lag and with moderate facilitation was now able to long sit independently for up to 30 seconds when he was wearing his AFO's and after gentle elongation of his hamstrings and facilitation of anterior pelvic tilt and sitting balance. He was beginning to prop forward and to the sides in long sitting with moderate facilitation on extended UE's, but with hands fist. He tried to reach for a toy with one hand and 3/5 times was successful in weight shifting and holding a toy, without losing his propping on the other hand. His grasps were in pronation. He was able to hold a toy for up to a minute before dropping it. He could also transfer objects from one hand to the other without dropping them.

With facilitation and with his AFO's, Amir was now able to straddle sit with UE's propped on small table and shift his weight forward to stand up and sit down. Without his AFO's, his feet and ankles were in excessive plantar flexion and pronation. Without facilitation, his standing was in excessive adduction (scissoring) with internal rotation. He loved to walk with support at the shoulders and trunk, but did not take full weight or weight shift, and used a more primitive stepping pattern. With maximum facilitation, he was able to bear 80% of his weight and weight shift and take steps.

Muscle tone continued to be underlying low tone especially in the trunk. Amir exhibited higher tone distally, especially in the biceps, pronator and finger flexors, adductors, hamstrings, plantar flexors and toe flexors, which increased during voluntary movement. He had shown increased passive ROM of hamstrings and adductors bilaterally. He did not exhibit any fixed contractures at this time. He had received AFO's, elbow splints and resting hand splints.

Continued therapy 3X/week recommended, along with home exercise program instructions, pediatric orthopedic evaluation for baseline, UE weight bearing splints, long sitter, adapted stroller/feeding/playing chair with tray for proper sitting, prone stander, gait trainer and adjustable bench.

**CENTRAL FLORIDA SPEECH THERAPY.: 1/27/08**

Amir had been receiving ST, sixty minutes per week in his home since 8/6/07. He had shown marked improvement with regard to drooling. He was now able to control his saliva independently. With regard to oral motor exercises, he continued to demonstrate hypersensitivity of the oral-facial musculature. His mother reported he would no longer tolerate having his teeth brushed on a daily basis. It was recommended to mother that the tolerance to these oral-facial activities be additionally addressed through varying the taste, texture, and temperature of solid/liquid items. With feeding skills, Amir was now able to masticate/swallow a bolus of solid food such as crackers. He was also attempting to master use of a straw for drinking liquids. He had demonstrated some success with this skill, and it was recommended that these skills continue to be addressed. Receptive language skills included the ability to understand changes in vocal tone, joint attention skills and appropriate eye contact. Expressive skills included the ability to produce /ka/, /ga/ and occasionally /ba/ in response to vocalizations. He had been observed to change his vocal intonations in response to varying pitch. It was recommended that skills, which addressed cause-effect, such as switch-adapted toys, be utilized. It was also recommended that an evaluation be conducted in order to assess the appropriateness of an alternative/augmentation communication system.

**AHEAD PROGRAM: 1/28/08**

Developmental evaluation. At time of evaluation, Amir was receiving PT 3X/week, OT 2X/week and ST 1X/week. The Batelle Developmental Inventory- 2<sup>nd</sup> Edition was administered. Scores were as follows:

<u>Domain</u>	<u>Raw Score</u>	<u>% Rank</u>	<u>Age Equiv.</u>
Adaptive			
Self Care	12	<1	7 Months
Personal-Social			
Adult Interaction	25	9%	12 Months
Self Concept/Social Role	11	5%	7 Months
Communication			

Receptive Comm.	14	<1	6 Months
Expressive Comm.	12	<1	8 Months
Motor Domain			
Gross Motor	12	<1	4 Months
Fine Motor	11	<1	6 Months
Cognitive			
Attention & Memory	20	5%	8 Months
Perception & Concepts	8	5%	6 Months

### **Records Received:**

Progressive Pediatric Rehabilitation, Inc: 1/25/08  
 Central Florida Speech Therapy.: 1/27/08  
 Ahead Program: 1/28/08  
 Newman, Brock M.D.: 1/2/08

## **Activities Of Daily Living**

### **Sleep Pattern**

**Arises:** 7 a.m.

**Retires:** 10 - 12 p.m.

**Average Hours Sleep/24 Hours:** 9 - 10 hours

**Sleep Difficulties:** He does not sleep through the night. He usually wakes at least twice during the night for a bottle. Sometimes he will not go back to sleep without his mother rocking him. He never falls asleep on his own, she has to rock him or pat him. It is very difficult to get him to take a nap, and when he does, he will only sleep for about 30 minutes.

### **Independence In**

**Dressing:** Totally dependent for all care.

**Housework:** Nonfunctional due to age, but also severity of motor deficits.

**Cooking:** Nonfunctional due to age, but also severity of motor deficits.

**Laundry:** Nonfunctional due to age, but also severity of motor deficits.

**Yard Work:** Nonfunctional due to age, but also severity of motor deficits.

## **Social Activities**

**Organizations Pre/Post:** Mother has signed up for a support group, Parent to Parent, but she has not started as yet. This group connects parents of children with CP together.

**Socialization Pre/Post:** They will go to the mall or over to the homes of other family members. They do not usually go to friends homes because Amir

will be fussy and they do not like to explain that he has CP. They do not go out much, but they are able to go out some.

## Personal Habits

**Smoking:** No smoking.

**Alcohol:** None.

**Drugs:** None.

**History of Abuse and/or Treatment Programs:** None.

## Socioeconomic Status

**Number in Residence:** 3, Mom, Dad and Amir.

**Type of Residence:** Apartment, ground floor.

## Income

**S.S.I. :** None.

**Wages:** Only income is from Radi as new physician.

**Medicaid:** Applied but did not qualify.

**Current Financial Situation:** They applied for the Healthy Kids Program through the State of Florida and this should start 11/1/07. They pay \$159 / month. They also are paying Cobra premiums from insurance they had in Atlanta because not all doctors will take Healthy Kids insurance. This is \$386.75/ month just for Amir in Cobra payments.

## Other Agency Involvement

**State Vocational Rehabilitation:** N/A.

**State Employment Services:** N/A.

**Rehabilitation Nurse:** N/A.

**Other Agency:** Ahead Program.

**Felony Convictions?** N/A.

## Education & Training

**Highest Grade Completed:** N/A.

## Observations



**Orientation:** Alert, but not to age appropriate level.

**Stream of Thought:** Not able to assess.

**Approach Toward Evaluation:** Open to examiner.

**Attitudes/Insight:** N/A.

**Appearance:** Overtly impaired.

## Tests Administered

As part of the evaluation process the Mullen Scales of Early Learning were administered to Amir. Amir is functioning at too low of a level for comparison with data associated with his age of 1 year and 3 months (15 months). His raw scores were comparable with age equivalent levels only.

Gross Motor Scale: His raw score of seven is comparable with an age equivalence of 4 months. He enjoys being held and he will realign his body while being held. He can rotate his head and move his arms and legs vigorously. He will hold his head upright and steady. He can sit supported with his head steady. He stands with his hands held and bounces. He sits with his arms free.

Visual Reception Scale: His raw score of twelve is comparable with an age equivalence of 9 months. He will fix and track with his eye. He will track 90 degrees and 180 degrees. He localizes alternating between objects. He stares at his own hand. He will localize both near and far. He will look for a dropped or hidden object. He attends to picture book.

Fine Motor Scale: His raw score of seven is comparable with an age equivalence of five months. He does hold his arms flexed and his hands fist. He will hold an object reflexively. He transfers objects, bangs them and drops them. He displays a refined grasp/thumb opposition. He uses two hands together. He will turn several pages of a book together.

Receptive Language Scale: His raw score of nine is equivalent to seven months of age. He does react reflexively to loud noises and he alerts to sounds. He responds to voice and face by smiling. He coordinates listening and turning. He responds to voice and face by vocalizing. He coordinates listening and looking. He enjoys self-interaction in the mirror. He recognizes his own name. He understands inhibitory words.

Expressive Language Scale: His raw score of four is comparable with an age equivalence of 3 months. Amir is able to make suck, swallow and chew movements. He does vocalize. He smiles and makes happy sounds. He will coo, chuckle and laugh.

## Conclusions:

Careful consideration has been given to all of the medical, psychosocial, and rehabilitation/mental health counseling data contained within this file and my report. In addition to this data, consideration is given to the research literature on hypoxic brain injury, cerebral palsy and developmental delay and attention is paid to the clinical practice guidelines for the treatment of these diagnoses promulgated by multiple sources and cited in the Life Care Plan. Correspondence with treating physicians was issued in order to ascertain their future treatment recommendations. Additionally, the life care plan was reviewed by our consulting Psychiatrist, Andrea Zotovas, M.D. All of these steps are taken to help in establishing the medical, case management, rehabilitation and psychological foundations for the Life Care Plan.

Amir remains severely neurologically compromised secondary to hypoxic ischemic encephalopathy experienced at birth on August 5, 2006. He demonstrates severe developmental delay in all areas of motor development, including gross and fine motor skills. Although cognitive delay is also present, the degree to which this approaches the severity of his motor delay is more difficult to assess. Unfortunately there are limits to the psychological and educational testing available to measure cognitive and intellectual development in very young children. A range of tools does exist to measure developmental milestones, but when a child is significantly delayed in motor function development this compromises his/her ability to demonstrate both physical and cognitive development, through assessment of such milestones using tools such as the Bailey scales, the Mullens Scales of Early Learning or the Hawaii Early Learning Profile. As he approaches age five, more tools will become available for assessment, but physical disability can always compromise accurate measurement of cognitive and intellectual function.

The Life Care Plan, attached as Appendix A, outlines all of his needs dictated by the onset of disability throughout his life expectancy. In addition to the recommendations specifically for Amir, counseling is provided to the family members in order to assist them in adjusting to his disability and the drastic effects this disability has on their lives.

Amir will require total care throughout his life expectancy. Home care assistance will provide the least restrictive environment while providing the support and interaction he requires. The attached Life Care Plan addresses the option of privately hiring a staff of caregivers versus the option of hiring caregivers through an agency. As a third option, for comparative purposes, facility care will be outlined post-age 21. Additionally, the Life Care Plan will outline all of Amir's medical care, equipment needs, supplies, medications, therapy/habilitation recommendations and other considerations as outlined by his treating physicians and therapists.

A Vocational Worksheet, attached as Appendix B, outlines Amir's capacity to earn pre-injury as compared to his capacity to earn post-injury, along with his loss of earning capacity and related vocational issues.

After you have had an opportunity to review this narrative report and the attached appendices, please do not hesitate to contact me should you have further questions.

Respectfully Submitted,

Paul M Deutsch, Ph.D, CRC, CCM, CLCP, FIALCP  
Licensed Mental Health Counselor, (FL MH#0000117)  
**PAUL M. DEUTSCH & ASSOCIATES, P.A.**

**ATTACHMENTS:** Appendix A - Life Care Plan  
Appendix B-Vocational Worksheet