Taipei City Pre-School Children Development Progress Evaluation Form

4 Months(3 months 16 days~5 months 15 days)

0.4

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞Development Milestone Check

Circle "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please circle "No".
Note: Items with (90% passed at 5 months) should be tested again at 5 months old if they were not passed at 4 months.

	1. (Lying on back) Both hands can be naturally opened instead of tightly fisted	Yes	No
	2. (Lying on back) Both hands naturally approach the chest bring both hands close to the chest (not necessarily touching)	Yes	No
★	3. (Lying on back) Head tilts abnormally to one side, hard to keep head straight up or turn head freely.	Yes	No
★	4. (Lying on back) when lying down quietly body often tilts to one side and hard to keep in midline.	Yes	No
	5. (Lying on back) Feeling abnormal resistance from both legs when bending and opening legs during diaper change.	Yes	No
★	6. (Lying on back) Obvious imbalance in frequency of usage and strength between two sides of legs and hands.	Yes	No
	7. (Lying on back) When pulled to sit, head is not keeping in line with movement of trunk , always lagging behind (90 % passed at 5 months)	Yes	No
	8. (Lying on back) Barely makes any sound even when playing with others.	Yes	No
★	9. (Lying down) Eyes can follow silently moving objects from left to right, up and down.(use a squeaky toy or object to make sound or touch the child's face lightly to attract the child's attention, then move the object silently to about 20cm in front of the eyes, and start to move sideways observe the child's reaction)	Yes	No
	10. (Lying on stomach) Able to support body with elbows, head rise perpendicular to the floor and able to hold for several seconds before slowly moving the head down. (No pass if the head struggles to rise up or falls heavily).	Yes	No
	11. (Upright) When the child is being held in upright position, the head and upper body can hold up for at least 10 seconds without wobbling.	Yes	No
★	12. Able to gaze at the person who is facing him/her, and shows interest in people.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:
☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.
Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

Taipei City Government Cares About You Version 2Revised in December, 2006 / Printed in 2019

……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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Taipei City Pre-School Children Development Progress Evaluation Form

6 Months(5 months 16 days~8 months 15 days)

0.6

Evaluation unit(Name of Agency):_____ Telephone: _____

Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker ☐ Parent ☐ Other _____

Original nationality:

Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day

Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day

(Pre-mature birth) Expected birthdate: ___ Year__Month__Day

(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day

Household Registration Address: _____

Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No".
Note: Items with (90% passed at 7 months) should be tested again at 7 months old if they were not passed at 6 months.

	1. (Lying on back) Feeling abnormal resistance from both legs when bending and opening legs during diaper change.	Yes	No
★	2. (Lying on back) Head tilts abnormally to one side, hard to keep head straight up or turn head freely.	Yes	No
	3. (Lying prone) Able to support body with palms and raise upper part of body from the floor. Head can turn freely in any directions(No pass if the head struggles to rise up or falls heavily, or is constantly tilted backwards.)	Yes	No
	4. (Sitting) Able to support self with both hands while sitting for about 5 seconds, head remaining stable in upright position, eyes looking forward (90% passed at 7 months)	Yes	No
	5. (Standing) Able to stand up straight with slight support on pitfalls from adults (buttock does not stick out); feet are able to move freely, such as bouncing, stepping in place or lifting one leg (90% passed at 7 months).	Yes	No
	6. Able to reach out single hand and touch toys within 15 cm. (only passes if both hands can achieve it)	Yes	No
	7. Able to grip tightly the toys in the hands and gently shake it. (passes only if shown as figure: thumb is out of the palm and participates in the gripping with other fingers.(only passes if both hands can achieve it) 	Yes	No
★	8. Can hold and retain an object. (e.g. toys, building blocks or food) in each hand at the same time for at least 3 seconds.	Yes	No
	9. Able to smoothly transfer an object or toy from one hand to the other.(does not pass if using pulling movement) (90% passed at 7 months)	Yes	No
★	10. Able to search for the ringing sound of a hand bell at about 20 cm to the rear of the left and right sides. (must be able to do with both sides).	Yes	No
	11. Barely makes any sound even if others play with him/her.	Yes	No
	12. Able to maintain eye contact with the caring adult, and will smile or laugh when the adult talks, laughs or presenting a toy.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:

☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application

The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.

Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

Taipei City Government Cares About You Version 2Revised in December, 2006 / Printed in 2019

……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____

Dear Parent:

Here is your child's screening result:

☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.

☐ Your child may need further observation for Question _____ of the examination at _____ months/years.

☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.

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Taipei City Pre-School Children Development Progress Evaluation Form

9 Months(8 months 16 days~11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____

Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker ☐ Parent ☐ Other _____

Original nationality:

Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day

Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day

(Pre-mature birth) Expected birthdate: ___ Year__Month__Day

(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day

Household Registration Address: _____

Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No".

★	1. (Lying prone) Roll over and back. (passes only if able to roll both ways)	Yes	No
★	2. (Sitting) Able to sit stably by him/herself for several minutes. (does not pass if: having to support with hands, back arches, or falls easily)	Yes	No
	3. (Standing) Able to stand up straight for at least 5 seconds when holding on to support. (table, or an adult's body parts)	Yes	No
★	4. Can hold and retain an object (e.g. toys, building blocks or food) in each hand at the same time for at least 5 seconds.	Yes	No
	5. Able to repeatedly shake toys to make sound.	Yes	No
★	6. Able to smoothly transfer an object or toy from one hand to the other. (does not pass if using pulling movement occurs) (90% passed at 7 months)	Yes	No
★	7. Turns head down to search for fallen toys.	Yes	No
	8. Able to look the adult in the eye, and laughs or smiles when the adult talks, laughs, plays peek-a-boo or teases with toys.	Yes	No
	9. Able to distinguish strangers from familiar people. (e.g. likes to be held by familiar adults, but is shy or intimidated by strangers)	Yes	No
★	10. Barely makes any sound even if others play with him/her.	Yes	No
	11. Doesn't understand other's words, e.g. does not respond when others calling his/her name or nickname, or when telling him/her "no".	Yes	No
	12. Usually fidgets around when held by adults, cannot stop grabbing objects nearby.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:

☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application

The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.

Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____

Dear Parent:

Here is your child's screening result:

☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.

☐ Your child may need further observation for Question _____ of the examination at _____ months/years.

☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.

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Taipei City Pre-School Children Development Progress Evaluation Form

1 Year
(11 months 16 days ~1 year 2 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No".

★	1. (Lying down) Able to sit up by him/herself from lying on back or stomach.	Yes	No
	2. (Standing) Able to stand up and take a few steps sideways by holding onto furniture.	Yes	No
★	3. Does not perform any movements with toys, such as shaking, squeezing, pulling or knocking, other than putting them in mouth or throwing them to floor.	Yes	No
	4. Unable to make any sounds spontaneously, or only makes throaty sounds; makes fewer than 3 sound combinations.(ba, di, goo)	Yes	No
	5. Understands simple daily life commands. (such as "come here", "give me" or "goodbye". Able to understand language and not responding to gestures or facial expressions of the adults)	Yes	No
	6. Able to imitate gestures such as clapping, waving good bye or praying with hints from adults. (verbal and gestural)	Yes	No
	7. Able to form play routine with adults during play. (e.g. performs simple, learned and specific gestures when adult sings a familiar nursery rhyme – such as padding adult's hands or pointing out fingers. If no such experience previously, see if child can quickly learn through simple interactive games such as "give me five"/"high five".)	Yes	No
★	8. Able to maintain eye contact, and laughs or smiles when the adult talks, laughs, plays peek-a-boo or teases with toys.	Yes	No
★	9. Usually plays by him/herself and doesn't respond even if adults calling his/her name (or nickname) repeatedly, does not lift head, turn back and look or get close to the adult.	Yes	No
★	10. Usually fidgets around when held by adults, cannot stop trying to grabbing objects nearby.	Yes	No
★	11. Constantly making unusual repetitive movements, such as staring at own hands, playing with own hands or spinning around.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:
☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.
Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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If you have related questions, please refer to the consulting phone line (see back of this form)

Taipei City Pre-School Children Development Progress Evaluation Form

1 Year 3 Months(1 year 2 months 16 days~ 1 year 5 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____

Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker ☐ Parent ☐ Other _____

Original nationality:

Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day

Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day

(Pre-mature birth) Expected birthdate: ___ Year__Month__Day

(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day

Household Registration Address: _____

Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No".

	1. Able to stand up without any support.	Yes	No
	2. Able to take steps without support.	Yes	No
	3. Able to draw or doodle freely with a pen. (adults can demonstrate for the child to imitate)	Yes	No
	4. Able to hold a small piece of snacks such as raisins and crackers with one hand, and place it into a small container like a film can. (adults can help holding the container)	Yes	No
	5. Will try to take out the small objects from the container.	Yes	No
★	6. Able to express his/her thoughts (through verbally speaking, hand gestures or looking(eye gaze) – e.g. nodding and shaking head means yes or no, palms up means "I want", finger points to desired object or direction). Select "No" if the child only pulls the adult's hands or clothes, and never "points" with fingers.	Yes	No
	7. Understands common daily life commands. (such as "drink milk", "clap hands", "time to sleep", "come to mommy". Should be able to understand without hand gestures or facial expression).	Yes	No
★	8. Makes hand gestures like clapping or waving goodbye under proper circumstances.	Yes	No
★	9. Able to maintain eye contact with adults and laughs or smiles when an adult is talking, laughing, playing peek-a-boo, or teasing him/her with toys.	Yes	No
	10.Unable to make any sounds spontaneously, or only makes throaty sounds; makes fewer than 3 sound combinations.(ba, di, goo).	Yes	No
★	11. Usually plays by him/herself and doesn't respond even if adults calling his/her name (or nickname) repeatedly,does not show responses such as lifting head, turning back and look to see or returning to get close to the adult.	Yes	No
★	12. Constantly making unusual repetitive movements, such as staring at own hands, playing with own hands or spinning around.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:

☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application

The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.

Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____

Dear Parent:

Here is your child's screening result:

☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.

☐ Your child may need further observation for Question _____ of the examination at _____ months/years.

☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.

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If you have related questions, please refer to the consulting phone line (see back of this form)

Taipei City Pre-School Children Development Progress Evaluation Form

1 Year 6 Months(1 year 5 months 16 days ~ 1 year 11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____

Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker ☐ Parent ☐ Other _____

Original nationality:

Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day

Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day

(Pre-mature birth) Expected birthdate: ___ Year__Month__Day

(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day

Household Registration Address: _____

Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No".

★	1. Able to stand up from sitting or lying down without needing to hold onto support.	Yes	No
	2. Able to walk steadily. (Select "No" if the following occurs: strange gait such as tip-toeing, Asymmetrical posture, unable to stop or turn, spacing between feet is wider than shoulders, tendency to fall, or arms in high guard position instead of being relaxed)	Yes	No
★	3. Able to bend down or kneel down to pick up objects on the ground and stand up with some support.	Yes	No
	4. Able to draw or doodle freely with a pen. (adults can demonstrate for the child to imitate)	Yes	No
	5. Able to hold a mall piece of snack such as raisins and crackers with one hand, and place it into a small container like a film can.	Yes	No
★	6. Able to express his/her thoughts (through verbally speaking, hand gestures or looking(eye gaze) – e.g. nodding and shaking head means yes or no, palms up means "I want", finger points to desired object or direction wanted). Select "No" if the child only pulls the adult's hands or clothes, and never "points" with fingers.	Yes	No
★	7. Able to comprehend half of common daily life commands. Understands more than half of common daily life commands (such as "give me XX", "come here", "give daddy", "throw XX away", "sit down" and "come to mommy". Should be able to understand without hand gestures or facial expression).	Yes	No
	8. Remembers where (s) he usually stores frequently used objects (e.g. toys and shoes), and can locate the required things immediately.	Yes	No
	9. Will look for the caretaking adults to play together; can be teased to laugh by adults talking, laughing and playing with toys.	Yes	No
	10. Shares happiness with others when happy, such as turns and smiles at adults, or shows his/her favorite things to adults.	Yes	No
★	11. Unable to make any sounds by him/herself, or only makes throaty sounds; makes fewer than 3 sound combinations.	Yes	No
★	12. Constantly performing unusual repeating movements, such as staring at hands, playing with hands or spinning around.	Yes	No
★	13. Usually plays by him/herself and doesn't respond even if adults calling his/her name (or nickname) repeatedly, does not show responses such as lifting head, turning back and look to see or returning to get close to the adult.	Yes	No

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:

☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application

The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.

Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____

Dear Parent:

Here is your child's screening result:

☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.

☐ Your child may need further observation for Question _____ of the examination at _____ months/years.

☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.

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Taipei City Pre-School Children Development Progress Evaluation Form

2 Year(1 year 11 months 16 days ~ 2 years 5 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth ： seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

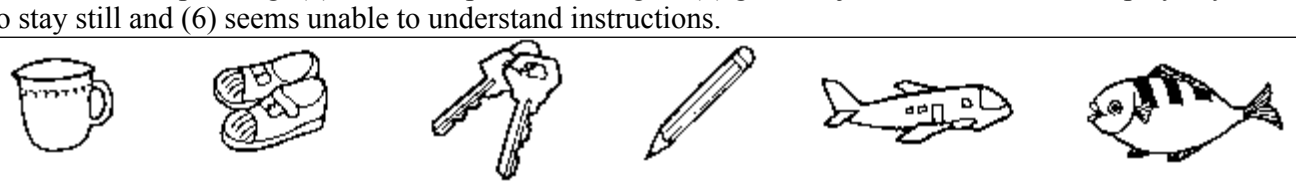
5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★ 1. Able to bend down or squat to pick up objects from the floor and stand up with some support.	Yes	No
2. Able to hold larger objects (e.g. small stools or big toys) and walk a short distance forward without falling (about 10 steps).	Yes	No
★ 3. Use at least 10 words or phrases on regular basis ("yum yum" for eat ； "woof woof" for dog is considered appropriate)	Yes	No
★ 4. (Test) Able to identify at least one picture (Figure 1: have an adult ask the following in sequence: "Which one is the pencil? Shoes? Key? Fish? Airplane? Cup", then repeat from the start again. Accurate only if the child select the right picture in both trials to avoid random). Accuracy: ___/___6___	Yes	No
5. Able to identify at least 4 body parts (have an adult ask the following in sequence: "where is the head, hand, foot, eye, ear, nose and mouth?") Accuracy:____/____7____	Yes	No
★ 6. Imitates house chores or the usage of various home supplies (such as using a broom for sweeping the floor, wiping things with tissue paper, playing with switches or kitchen utensils)	Yes	No
★ 7. Is motivated to learn spontaneously, such as actively finding toys to play with or read story books.	Yes	No
★ 8. Shares happiness with others, such as turns and smiles at adults, or shows his/her favorite things to adults.	Yes	No
9. Unable to imitate saying single words because (1) (s)he has no desire to do so, or (2) has difficulty with pronunciation.	Yes	No
10. Usually plays by him/herself and doesn't respond even if adults calling his/her name (or nickname) repeatedly, does not show responses such as lifting head, turning back and look to see or returning to get close to the adult.	Yes	No
11. Being uncooperative during testing and displays any of the following behaviors: (1) not interested in demonstration or instruction, (2) eyes do not follow where the adult is pointing, (3) refuses to point with fingers (4) grabs object from the adult and plays by his/her own, (5) runs around and hard to stay still and (6) seems unable to understand instructions.	Yes	No

Figure 1



Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:
☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.
Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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Taipei City Pre-School Children Development Progress Evaluation Form

2 Years 6 Months (2 years 5 months 16 days ~ 2 years 11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month____Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors:
①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives ②☐ Unfavorable socio-economic status
③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★ 1. Able to bend down or squat easily to pick up objects from the floor and stand up without support.	Yes	No
★ 2. Able to climb up the stairs with support of handrail or wall.	Yes	No
3. Able to jump with both feet off the ground. (both feet must be able to jump and land together; not passed if obvious imbalance occurs)	Yes	No
★ 4. Able to unscrew small bottle caps. (adults can slightly unscrew it to make it looser)	Yes	No
★ 5. Able to read and flip the pages of a board book or cloth book.	Yes	No
★ 6. Countless spoken phrases and words with most being complete, e.g. "apple" instead of "ple".	Yes	No
7. Can use sentences composed of 2-word phrases to express him/herself most of the time. (such as "mommy-hold", "want water")	Yes	No
8. (Test) Able to identify at least 4 pictures. (Figure 1: have an adult ask the following in sequence: "Which one is the pencil? Shoes? Key? Fish? Airplane? Cup", then repeat from the start again. Accurate only if the child select the right picture in both trials to avoid random) Accuracy:____/____6____	Yes	No
★ 9. Able to identify at least 6 body parts. (have an adult ask the following in sequence: "where is the head, hand, foot, eye, ear, nose and mouth?")	Yes	No
10. Unable to speak clearly, incomprehensible even to the adults who have the closest contact with the child with the closest relationship.	Yes	No
★ 11. Usually plays by him/herself and doesn't respond even if adults calling his/her name (or nickname) repeatedly, does not show responses such as lifting head, turning back and look to see or returning to get close to the adult.	Yes	No
12. Being uncooperative during testing and displays any of the following behaviors: (1) not interested in demonstration or instruction, (2) eyes do not follow where the adult is pointing, (3) refuses to point with fingers (4) grabs object from the adult and plays by his/her own, (5) runs around and hard to stay still and (6) seems unable to understand instructions.	Yes	No

Figure 1

Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:
☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.
Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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Taipei City Pre-School Children Development Progress Evaluation Form

3 Years (2 years 11 months 16 days ~ 3 years 5 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors: ①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives
②☐ Unfavorable socio-economic status ③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★	1. Able to bend down or squat easily to play with toys and stand up without support.	Yes	No
	2. Able to climb up stairs by supporting on handrail or wall.	Yes	No
	3. Able to run. (select "No" if posture is awkward or falls frequently)	Yes	No
	4. Able to make several jumps off the ground at a time. (both feet must be able to jump and land together; not passed if obvious imbalance between both feet is observed).	Yes	No
	5. (Test)Able to imitate drawing a straight vertical line. (Figure 1: have an adult demonstrate first by drawing a straight line between the bee and flower pot, then let the child draw; if the line connects the bee and the flower pot at its both end without breaking, then it is considered as passing)	Yes	No
★	6. Able to hold a conversation using adequate short phrases of 2 to 3 words, and answers questions relevantly.	Yes	No
	7. Able to actively ask questions with at least one type of Wh sentences (e.g. what is …? Why is …? Who is …? Where is …?).	Yes	No
★	8. (Test) Able to identify at least 4 pictures. (Figure 1: have an adult ask the following in sequence: "Which one is the pencil? Shoes? Key? Fish? Airplane? Cup", then repeat from the start again. Accurate only if the child select the right picture in both trials)	Yes	No
	9. (Test) Understands the description of at least 2 pictures. (Figure 2: have an adult ask the following: "Which one is used for opening doors? Which one swims in water? Which one is used for writing? Which one do we wear on feet? Which is used for drinking water? Which one flies in the sky?")	Yes	No
	10. (Test) Able to match identical pictures (Figure 2: adult points to the" key "on the left "Which one is the same? " then point to the "pencil" on the right and asks: the same question. To pass, both must be correctly identified.	Yes	No
	11. Unable to speak clearly, incomprehensible even to the adults who have the closest contact with the child.	Yes	No
	12. Usually unable to correctly use pronouns like "you" or "I"; for example, (1) "You" and "I" are used oppositely, or (2) calls him/herself by name (or nickname) instead of using "I".	Yes	No
	13. Being uncooperative during testing and displays any of the following behaviors: (1) not interested in demonstration or instruction, (2) eyes do not follow where the adult is pointing, (3) refuses to point with fingers, (4) grabs object from the adult and plays by his/her own (5) runs around and hard to stay still , and (6) seems unable to understand instructions.	Yes	No

Figure 1

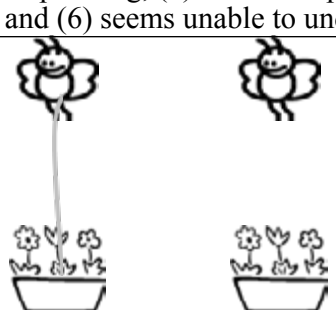
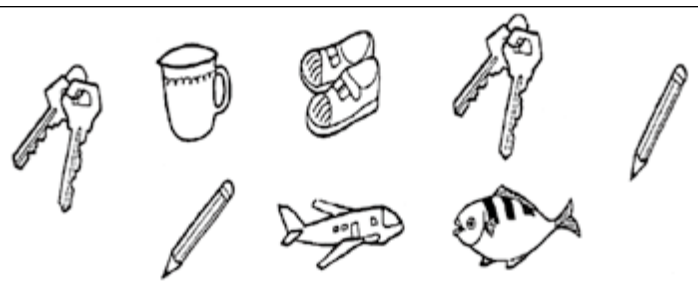


Figure 2



Please proceed to the designated medical institutions listed in the back of this form for further examination if: 1) two or more of the above questions were answered in the shaded fields; 2) any of the questions marked with ★ were answered in the shaded field, or 3) if the person filling out the form concerns that the child has there abnormal functions or behaviors. Please answer the following questions about Disability Card:
☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
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Taipei City Government Cares About You Version 2Revised in December, 2006 / Printed in 2019

……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
※Pre-School Children Development Progress Online screening Form----Download the form from the website of the Taipei City Government Department of Health
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Taipei City Pre-School Children Development Progress Evaluation Form

3 Years 6 Months(3 years 5 months 16 days ~ 3 years 11 months 15 days)

3.5

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors: ①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives
②☐ Unfavorable socio-economic status ③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★	1. Able to bend down or squat easily to play with toys and stand up without support.	Yes	No
	2. Able to climb up stairs by slightly supporting on handrail or wall.	Yes	No
	3. Able to run. (select "No" if posture is awkward or falls frequently)	Yes	No
	4. Able to make several jumps at a time off the ground. (both feet must be able to jump and land together; select "No"if obvious imbalance between both feet is observed)	Yes	No
	5. (Test) Able to imitate drawing a straight horizontal line. (Figure 1: have an adult demonstrate first by drawing a horizontal line between the bee and flower pot, then let the child draw; if the line connects the bee and the flower pot at both its ends without breaking, then it is considered as passing)	Yes	No
★	6. Able to hold a conversation using short phrases of 3 to 4 words, and answer questions relevantly.	Yes	No
	7. Able to actively ask questions with at least one type of sentence. (e.g. Why is it? Where is it?)	Yes	No
	8. (Test) Able to state the function of at least 3 objects (Figure 4: have adult point to the cup, shoes, key and pencil, and ask "What is this used for?". If the child cannot answer the first question, hints like "The cup is used for drinking water" can be given, but only for the first question).	Yes	No
	9. (Test) Able to understand the concept of "big" (Figure 2: ask "Which one is bigger?" Pass only if correctly answered twice. The form should be turned to a different orientation when asking to avoid random guessing).	Yes	No
	10. (Test) Able to correctly identify a named color (Figure 3: ask: "Which one is red? Yellow? Blue? Green?" or "which one is apple red (Which one is red like apple?)? Banana yellow? Sky blue? Leaf green?" Repeat the questions again to make sure the child is not randomly guessing; only passing if correct colors are identified twice)	Yes	No
★	11. Unable to speak clearly, incomprehensible even to the adults who have the closest contact with the child.	Yes	No
★	12. Often says something irrelevant to context, or not for the purpose of communication.	Yes	No
	13. Being uncooperative during testing and displays any one of the following behaviors: (1) not interested in demonstration or instruction, (2) eyes do not follow where the adult is pointing, (3) refuses to point with finger (4) grabs object from the adult and plays with him/herself, (5) runs around for the hard to stay still and (6) seems unable to understand instructions.	Yes	No

Figure 1

Figure 2

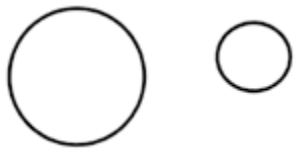
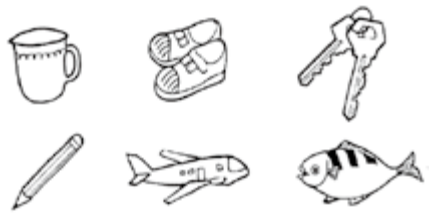


Figure 3

Figure 4



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☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
The screening test of the current age range is considered passed if 1) less than two of the above questions were answered in the shaded fields, and 2) no questions with ★ at the front that were answered in the shaded fields.
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Taipei City Government Cares About You Version 2Revised in December, 2006 / Printed in 2019

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Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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Taipei City Pre-School Children Development Progress Evaluation Form

4 Years(3 years 11 months 16 days ~ 4 years 11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors: ①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives
②☐ Unfavorable socio-economic status ③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★	1. Able to bend down or squat easily to play with toys and stand up without support.	Yes	No
	2. Able to run. (not passed if posture is awkward or falls frequently)	Yes	No
	3. Able to jump off the ground. (both feet must be able to jump and land together; not passed if obvious imbalance between both feet is observed)	Yes	No
	4. Able to climb up the stairs, placing one foot on each step, without holding onto the handrail or wall.	Yes	No
★	5. Able to hold a conversation using short phrases of 4 to 5 words, and answers relevantly.	Yes	No
★	6. (Test) Able to identify a color. (Figure 1: points to the red, yellow and green circles and asks accordingly: "What is this color?" Pass if answered 1 color correctly)	Yes	No
	7. (Test) Able to understand at least 2 prepositions (Figure 2: lead the child to look at the cow head and 4 birds, then ask accordingly "Which bird is above(on?) the cow? Below(under?)? In front of it? Behind it?" Pass if answered 2 correctly)	Yes	No
	8. (Test) Imitate the sentence " The Boy-wants-a-bicycle". (Adult reads the sentence first, and then asks the child to repeat. Select "no"if 4 or more words were incorrect)	Yes	No
	9. (Test) Able to state the function of the 4 objects. (Figure 3: have adult point to the cup, shoes, key and pencil, and ask "What is this used for?" Pass if all are correctly answered).	Yes	No
	10. (Test) Able to count 5 dots, one at a time (Figure 4: ask "Count to see how many dots there are?" and ask the child to count it out loud. Only passes if the first 5 dots are counted out loud with corresponding (one on one) pointing of the dots)	Yes	No
★	11. Speaks unclearly, often being asked to speak again or requiring translation from caregivers.	Yes	No
★	12. Often talks to him/herself or keep talking about things of interest, like tape recorder playing back, regardless of other people's reactions.	Yes	No
	13. Stands out in a group because of any of the following behaviors: (1) unable to remain in seat in the class, walks around or leaves the classroom; (2) frequently comes into conflicts or argues with classmates or teacher and thus is isolated or rejected; (3) usually plays alone instead of with friends; (4) unable to keep up with classmates during class and often needs assistance.	Yes	No

Figure 1

Figure 2

Figure 3

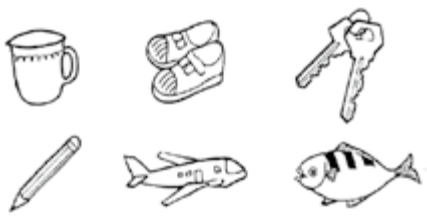

Figure 4

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Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
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Taipei City Pre-School Children Development Progress Evaluation Form

5 Years(4 years 11 months 16 days ~ 5 years 11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year_____Month___Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
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4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors: ①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives
②☐ Unfavorable socio-economic status ③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

★	1. Able to bend down or squat easily to play with toys and stand up without support.	Yes	No
	2. Able to run. (not passed if posture is awkward or falls frequently)	Yes	No
	3. Able to make several jumps off the ground at a time. (both feet must be able to jump and land together; not passed if obvious imbalance between both feet is observed)	Yes	No
	4. Able to walk down stairs without support of the handrail or wall, placing one foot on each step.	Yes	No
	5. (Test) Learn to copy 3 figures from ┼□△◇ (Figure 1: lines should be continuous without breaks or obvious disorientation, the number of angles is correct, and no difficulty with forming angles)	Yes	No
★	6. Able to describe what happened to self to others. (such as information from teacher or things that happened in school).	Yes	No
	7. (Test) Can name 4 colors. (Figure 2: points to the circles and ask accordingly "What color is this? Yellow? Blue? Green?")	Yes	No
	8. (Test) Has quantitative concept of "7". (Figure 3: Ask the child to "Circle 1 dot at a time, and stop after you've circled 7 circles, and give me the pen". If the child circles 6 or 8 dots, encourage him/her to check again, and score his/her performance based on the second test)	Yes	No
	9. (Test) Able to read Arabic numbers. (Figure 4: points to 5, 8, 7, 4, 6, 3, 9, 2 and ask accordingly "What number is this?" Pass if 7 numbers are answered correctly)Accurate digits:____/____8	Yes	No
★	10. Speaks unclearly, often being asked to say again or requiring translation from caregivers.	Yes	No
★	11. Able to speak in sentences, but stutters obviously. Child has been stuttering in two out of ten spoken sentences for over half a year.	Yes	No
★	12. Often talks to him/herself or keep talking about things of interest, like tape recorder playing back, regardless of other people's reactions.	Yes	No
	13. Stands out in a group because of any of the following behaviors: (1) unable to remain in seat in the class, walks around or leaves the classroom; (2) frequently comes into conflicts or argues with classmates or teacher and thus is isolated or rejected; (3) usually plays alone instead of with friends; (4) unable to keep up with classmates during class and often needs assistance.	Yes	No

Figure 1

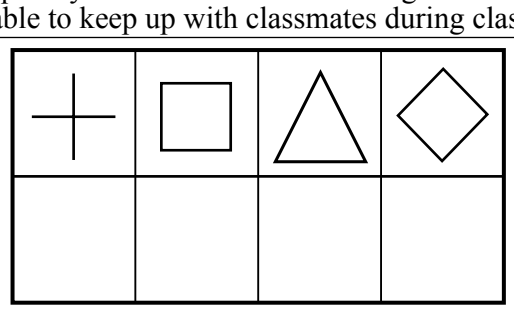

Figure 2

Figure 3

Figure 4

5 8 7 4 6 3 9 2

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☐ Yes (Disability category _____ Level _____) ☐ No ☐ Under application
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Please continue to monitor the development of the child by using the screening form of the corresponding age range of the child's age .

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……(Please tear on the dotted line)……

Children Screening Return Slip

Name of child:_____ Examination unit(name of agency): _____Date: _____
Dear Parent:
Here is your child's screening result:
☐ Your child's current development status is comparable to the development norm of the same age group; please make sure to take your child for vaccination and regular health checkups.
☐ Your child may need further observation for Question _____ of the examination at _____ months/years.
☐ Your child needs further confirmation for Question _____ of the examination at _____ months/years. Please bring your child to an early intervention and assessment institution for further examination. If the child needs further intervention and social welfare assistance, the physician will make the necessary referral and reporting of your child's condition to the Taipei Early Intervention Reporting and Referral Center (EIRRC) to provide you with information of related services.
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Taipei City Pre-School Children Development Progress Evaluation Form

6 Years(5years 11 months 16 days ~ 6 years 11 months 15 days)

Evaluation unit(Name of Agency):_____ Telephone: _____
Your name: _____ Your identity/role/relationship to the child: □ Medical personnel ☐ Teacher ☐ Social Worker
☐ Parent ☐ Other _____
Original nationality:
Father: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____
Mother: ☐ Taiwan ☐ Mainland China ☐ Thailand ☐ Indonesia ☐ Vietnam ☐ Cambodia ☐ Myanmar ☐ Others: Please specify: _____

☞ Basic Information of Child

Name of child:_____ Gender: ☐ Male ☐ Female Evaluation date: _____ Year_____ Month ____ Day
Personal ID Number: ☐☐☐☐☐☐☐☐☐☐ Birthdate: _____ Year____Month___Day
(Pre-mature birth) Expected birthdate: ___ Year__Month__Day
(Required, please fill in corrected age for premature birth) Chronological age: ____ Years_____ Months _____ Day
Household Registration Address: _____
Contact address: _____ Phone number: (Day)_____(Night) _____

☞ High Risk Factors of Developmental Delay

1.①☐ Pre-mature birth (less than 36 weeks pregnancy) ②☐ Birth weight less than 2500 grams ③☐ None

2.Congenital abnormalities:
①☐ Chromosomal abnormality (e.g. Down syndrome, Turner's syndrome) ②☐Cranial-Facial abnormality(e.g. Cleft lip and cleft palate, external ear abnormalities)
③☐ Congenital metabolism abnormality (e.g. phenylketonuria, thyroid dysfunction) ④ ☐Hydrocephalus or spina bifida ⑤ ☐Craniosynostosis
⑥☐ Congenital cardiovascular disease ⑦☐ Limb defects and malformation ⑧ ☐Others_____ ⑨ ☐None of the above

3. Pre-pregnancy, pregnancy and post parturition issues(pregnancy, delivery and after birth):
①☐ Infection of Rubella, German measles in the first trimester ②☐ Abnormal bleeding, diabetes, pre-eclampsia, syphilis, alcoholism, smoking during pregnancy
③☐ Decreased fetal heart rate during pregnancy, meconium aspiration, respiratory distress, ER treatment for suffocation and asphyxiation, _____ days spent in the incubator. ④☐ Low Apgar score: after 5 minutes <7(or ≤ 6); please refer to the Baby's Birth Condition Records in the Children's Health Booklet
⑤☐ Has the following issues after birth：seizure, no breathing, repeated vomiting, low body temperature or feeding difficulties
⑥☐ Severe jaundice requiring blood transfusion ⑦☐ Others_____ ⑧☐ None of the above

4. Brain disease or injury:
①☐ Hydrocephalus ②☐ Bleeding or hypoxia ③☐ Brain infection ④☐ Epilepsy ⑤☐ Brain tumor ⑥☐ Others_____ ⑦☐ None of the above

5. Family history or environment factors: ①☐ Hearing/ visual impairments , mental retardation and psychiatric diseases in close relatives
②☐ Unfavorable socio-economic status ③☐ Orphan or child abuse victim ④☐ None of the above

☞ Development Milestone Check

Select "Yes" if your child fits with the description of the item. If not, or the child does not exhibit signs that fit with the description of the item, please select "No". Questions denoted with (Test) has accompanying figure shown below, please conduct the test and record the child's reaction.

	1. Able to hop on one foot for 4 times. (only passes if both feet can perform the movement)	Yes	No
★	2. Able to fold a paper in half and make a fold line. (adult demonstrates first, the fold line does not have to be perfect)	Yes	No
	3. Able to copy simple characters (Figure 1: adult writes the「人」character in the box below, then say "write the same character as above". Only passes if all 3 characters are correctly written)	Yes	No
★	4. (Test) Usually able to tell a simple story clearly (Figure 2: points to panel ① and says "Look, there's a banana peel here. Tell me what is happening to the child in these pictures". Guide the child by pointing to panels ②③④, and record the child's verbal response) _____ Scoring: child passes if at least 2 cause-and-effect relationship in the figures are stated [such as **AB, AC, BC or ABC**] A:【Cause】Not careful, overlooked, stepped on banana peel (slippery thing) →【effect】slips, falls B:【Cause】Slips, falls →【effect】Crying, sitting, has a bump, hurts C:【Finally】Mommy (doctor, nurse, big sister) has come, saves him, takes care of him, patches him, sticks the bandage_____	Yes	No
★	5. (Test) Able to count from 1 to 30 (Hints given:___, Corrections___ Only passes if 1 hint and 1 correction is given)	Yes	No
★	6. (Test) Has quantitative concept of "7". (Figure 3: Ask the child to "Circle 1 dot at a time, and stop after you've circled 7 circles, and give me the pen". If the child circles 6 or 8 dots, encourage him/her to check again, and score his/her performance based on the second trial)	Yes	No
	7. (Test) Has quantitative concept of "13". (Figure 4: Ask the child to "Count how many dots are here?" If the child counts 12 or 14 dots, encourage him/her to count again, and score his/her performance based on the second trial)	Yes	No
★	8. (Test) Able to state at least 3 antonyms (e.g. Ask "Brother is a boy, sister is a____? Summer is hot, winter is____? Airplanes fly in the sky, cars are on the____? Elephants have long noses, mice have____noses?" Only passes if 3 questions are answered correctly)	Yes	No
	9 (Test) Shows common basic knowledge (Ask "How many fingers are there on one hand" How many eyes do you have? How many feet does a kitty have? What are fire trucks for? 1 plus 1 equals?" Only passes if 4 questions are answered correctly. Accuracy:____/____5_____	Yes	No
★	10. Speaks unclearly, often being asked to say again or requiring translation from caregivers.	Yes	No
★	11. Able to speak in sentences, but stutters obviously. Child has been stuttering in two out of ten sentences for over half a year.	Yes	No
★	12. Often talks to him/herself or keep talking about things of interest, like tape recorder playing back, regardless of other people's reactions.	Yes	No
★	13. Stands out in a group because of any of the following behaviors: (1) unable to remain in seat in the class, walks around or leaves the classroom; (2) frequently comes into conflicts or argues with classmates or teacher and thus is isolated or rejected; (3) usually plays alone instead of with (4) unable to keep up with classmates during class and often need assistance.	Yes	No

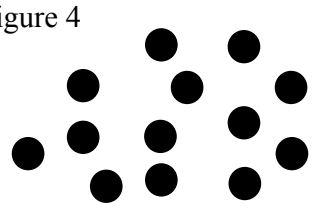
Figure 1

人	木	田	工
人			

Figure 2

Figure 3

Figure 4



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