



NICU and High-Risk Pediatric Development Clinic

The High-Risk Infant Follow-up clinic is a service of the Michael R. Boh Center for Child Development. The clinic's primary role and goal is to provide neurodevelopmental follow-up of infants who are graduates of the NICU. This includes infants who were less than 32 weeks gestation at birth; infants with chromosomal or major congenital anomalies; infants with a history of neonatal abstinence syndrome; infants with gestational age >32 weeks, who have history of hypoxic-ischemic injury or seizures.

FOR REFERRING CLINICIANS:

The clinic is staffed by medical and rehab clinicians, (Occupational Therapy, Physical Therapy, Speech), along with a social worker. The clinicians involved use up-to-date clinical guidelines and assessment tools to assist with the early detection of developmental problems. Such tools include the Hammersmith Infant Neurological Examination (HINE), used for the early detection of cerebral palsy; the motor portions of the Bayley Scales of Infant Development, 4th edition (BSID-4), used for evaluation of motor delays; and the NeoEAT, used for the evaluation of early swallowing problems in infants.

Referrals for new patients to the clinic are usually made at the time of discharge from the NICU, and most infants are seen within 2-4 weeks of discharge. Referrals are also accepted from any primary care clinician or specialty physician, who has concerns about developmental issues in a child under the age of 2 years with a history of prematurity. These referrals may be routed electronically to the medical director for the clinic and the children are usually scheduled within 2 weeks.

Follow-up patient appointments are set up based on each individual patient's needs, although most infants are seen every 3-6 months, until age 2 years. Usually by that age, the infant has been seen enough times to establish a clear-cut diagnosis and disability OR the trajectory of development indicates no need for frequent follow-up visits. Children may be seen yearly after that point.

The clinic meets weekly. The **Cardiac Developmental Clinic** is incorporated into the High-risk Follow Up Clinic and provides neurodevelopmental follow-up for children with complex congenital heart disease. These infants may have a variety of complex congenital heart lesions, but have in common a history of cardiac surgery performed under 1 year of age.

FOR PARENTS: What to expect at your visit

1. Each infant is scheduled in a 2-hour time slot. On your baby's initial visit, you will be seen by the entire team which includes Pediatrics, OT, PT, Speech and Social Work.
2. After being checked in, you and baby will meet one of the Pediatric clinicians, either the physician or Nurse Practitioner, who will review your baby's NICU and life story thus far and conduct an exam.
3. Next, the other members of the team rotate in, often with OT and PT seeing the baby in tandem to assess fine and gross motor skill, along with visual tracking. Speech will assess swallowing and feeding issues, and often like to observe the infant feeding. Often the Speech evaluation is done after OT/PT, because the previous workout makes the baby hungry or upset enough to want to eat. Social Work often is the final clinician, who checks on service needs, such as WIC or Early Steps.
4. After seeing everyone, the Pediatric clinician will return to the room to review the findings, discuss what needs to be done if there was anything out of the ordinary, and discuss planned clinic follow-up visits. While there is a planned suggested follow-up schedule for high risk infants, every baby is different. If your baby needs direct services from any of the clinicians who performed an evaluation during the visit, that clinician will coordinate with you for a follow-up appointment.
5. Follow-up appointments are then scheduled by the medical assistants.