ALL BLESSINGS INTERNATIONAL
Finding Families For God's Children

Waiting Child List
Taiwan
1. Birth History: GA: 37+6 weeks; birth weight: 2580g, birth length: 48 cm; CS delivery.

When CL was 5-month-old, he was admitted to the hospital for fever and urinary tract infection caused from VUR. It was during the hospitalization period that CL was found with a duplex kidney and double ureters. Regular OPD follow-up exam is necessary. (urinary test needs to be mad every three weeks and kidney follow up has to be done every 6 months.)

2. When CL was 17 months old, he was found unbalanced on his feet when he was walking. He tended to drag his right leg behind. Thus, his caregiver consulted a pediatrician due to the fact that CL walked independently but with an abnormal gait. As a result, he was diagnosed with cerebral palsy – mild hemiplegic CP of the right side of his body. Furthermore, he has spastic hypertonic muscle tone on the right side of his lower extremity. At present, he is wearing AFO (Ankle-Foot Orthosis) for walking training. In addition, from this assessment, it was found that CL had motor and language/speech developmental delays. He barely performed oral expression. Currently, CL is attending early intervention education programs including language/speech therapy, occupational therapy and physical therapy at two different hospitals.

3. When CL was two years old, he had recurrent spasticity and was diagnosed with epilepsy. Thus, he has been on medicine treatment (Trileptal) for epilepsy since 6th December of 2013 but within six months after that, he had seizures twice. On 1st August of 2014, the dose was increased to 4ml given a twice-a-day regimen. Referring to the result of the EEG test performed on 19th December of 2014, the abnormal electrical activities of his brain were recorded. Therefore, besides the antiepileptic medicine, CL has been prescribed additional medicine (Keppra) of 2ml twice-a-day and Beexix of 50 mg/tan twice a day.

4. According to the report filed on December 23rd, 2014, CL was cognitively delayed, motor skill and language developmental delay. He was also eligible to apply for Disability ID Card-mild intellectual deficiency and the Card was issued in February, 2015
1. The Child appears to be in good health, please refer to the Medical Summary dated on 14 April 2016 for further information.
2. The Child was struggling to adjust at Foster Family A and he was found having significant developmental delays. He tended not to interact with people and often cried for no reasons. Thus, he was administered jointed assessment on 4/Aug/2016 and the result indicated that the Child had combined developmental delays and autism spectrum disorder. He is a holder of Developmental Delay Disability Handbook with mild level. Please refer to the Jointed Assessment for Child Development Report for detail information.
"1. H-H was born through natural birth; GA: 39 weeks, weighted 2980g, length: 49.5cm, apgar score of 9 to 9.
2. H-H was hospitalized on October 16th, 2014 due to suspect child abuse. After medical examination, right femur shaft fracture was found but did not need to stay in the hospital.
3. H-H was hospitalized on October 27th, 2014 due to shortness of breath. Her discharge summary showed that she had acute bronchiolitis (viral related), as well as Right proximal femoral fracture and left clavicular fracture with callus formation. Please view more details in the discharge summary on November 3rd, 2014.
4. H-H had a physical examination on March 21st, 2018. It was found that H-H is farsighted with 5.0 diopters and Astigmatism 4.0 diopters; she is already wearing prescription glasses. H-H’s hearing is normal and is able to hear 20-25dB and her growth percentile was less than 3. She was also diagnosed with speech developmental delay and social developmental delay. Please view more details in the Medical summary and other attachments.
5. H-H had a surgery on May 22nd, 2018 due to developmental dysplasia of the hip, right, status post right Pemberton acetabuloplasty; she was also diagnosed with laryngomalacia and both femoral+tibia+fibula+clavicle+right ulnar fracture due to child abuse. Please view more details in the discharge summaries on May 22nd, 2018 and June 26th, 2018 from National Taiwan University Hospital.
6. H-H had a development assessment on May 25th, 2017, which resulted in mixed language delay, gross motor delay and borderline fine motor development delay. H-H had another development assessment on August 2nd, 2018, it resulted in cognitive delay, mixed language delay, gross motor delay, fine motor development delay and borderline social and emotional development delay. Please view more details in the Joint assessment report on August 2nd, 2018. H-H is a holder of mild disability manual (for oral expression ability); thus, she has received therapy sessions four times a week (language therapy thirty minutes a week, occupational and physical mixed therapy for an hour and a half per week).
7. H-H started receiving psychological consultation sessions since April 2018, which mainly to discuss about her family background. Please view more information in the consultation reports."
"1. Birth history: GA: 26 weeks; birth weight: 728g. The Child was admitted to the hospital due to low birth weight with preterm birth and respiratory distress. During the hospitalization period, the Child received a ligation of PDA and a laser surgery for ROP. Please refer to Discharge Summary dated on 13-Dec-2006 issued by National Taiwan University Hospital for detail information.

2. Vision: According to the Vision Analysis Report dated on 4-Aug-2017, the ophthalmologist's diagnosis was of the following:
- Left eye: Amblyopia, alternating exotropia, astigmatism
- Right eye: Myopia, astigmatism
The latest examination shows that the Child has 20/100 vision in the right eye and 20/40 vision in the left eye before correction. She is wearing glasses for vision correction. In addition, she uses a pad to cover the right side of her glasses in daytime to correct the significant difference in vision between two eyes.

3. Atopic dermatitis: The Child had received both traditional Chinese medicine treatment and western medicine treatment for atopic dermatitis during her foster care placement period. At present, the Child stays in the institution and does not receive regular medical treatment. She would avoid eating allergic food (ex. mango, chocolate, taro, sea food with shells, etc.) from daily meals. On the other hand, the Child tends to have rash on her back, chest and neck and feel itchy during the change of seasons or in the weather with heat. Usually, she uses the cold packs for relief.

4. According to the results of physical examination dated on 4-Dec-2016, the Child was in good health except the follow up for her vision impairment and low BMI. The blood test performed on 11-Oct-2016 indicated that the Child had an HIV negative.

Academic Learning: The Child had developmental delays and received speech-language therapy, physical therapy and occupational therapy treatment before she entered the Elementary School. She attended the assessment for special education placement but was not qualified for the program. However, her performance on academic learning was still delay. Thus, she attends resource classes for courses of Chinese, English and Math. She is a sixth grader."
1. GA: 39 weeks + 6 days; birth weight: 3,380 g; birth height: 48 cm; head circumference: 33.5 cm; chest circumference: 35 cm.
2. Y-S's physical exam report on 19 September 2014 reveals nothing abnormal.
3. The placement social worker arranged 12 sessions of art therapy for Y-S from 14 January to 12 March 2015, hoping to increase Y-S's interaction with peers through sharing and to help him express his inner emotions through art creation. It was learned in such sessions that Y-S had poorer cognitive and language abilities. During a session of guided art creation, the teacher found that Y-S had low self-identification, which could be the cause for his tendency to compete with others.
4. Through the art therapy, Y-S was observed to be less capable of certain skills. A group evaluation of his development was therefore arranged for 27 March 2015, which turned out that he was suspected of developmental delays in cognition, language, and motor. (Please read the comprehensive report on his development issued by Hualien Tzu Chi Hospital.)
   Y-S was enrolled in a group toy brick course from early 2015 to the end of the first half of the year to strengthen the muscle strength of his hands. An advanced course for him early next year is considered.
   Y-S received speech therapy from March to 28 August 2015. The therapy is over now. (It is not clear whether Y-S had been in an early intervention program before 2015.)
1. GA: 36 weeks + 1; birth weight: 2350g.
2. Infantile cerebral palsy with left-sided weakness: According to a certificate of diagnosis issued by Mackay Memorial Hospital (dated 20 November 2013), Child1 has difficulty standing due to infantile cerebral palsy with left-sided weakness and needs ankle-foot orthoses (AFOs). He is now wearing orthotics as assistance to his locomotion.
3. Epilepsy: Child1 was hospitalized in Mackay Memorial Hospital’s Taitung Branch for suspected sepsis and seizure in April 2010. After he was placed for foster care in late 2010, he still visited hospital regularly and was on medication. The foster family took him to the hospital for an examination on 26 September 2012. The results of EEG and MRI exams were normal. Child1 does not have a seizure again and is not taking any medicine at present. (Please refer to discharge summary dated 24 April 2010 and MRI report on 26 September 2012 for details.)
4. Periventricular leukomalacia (PVL) on the right side of the brain and optic atrophy in both eyes: Child1 underwent a surgery on both eyes on 13 November 2014 and needed to return to the hospital every other week after that. At a school teacher’s suggestion between October and November 2015, the foster family took Child1 to the hospital where he was found to have PVL in his right brain, which caused optic atrophy in both of his eyes. His best corrected vision was below 1/20 in both eyes, so the foster family was advised to discuss with Child1’s school on ways to help him develop his auditory learning to make up his vision deficient. (Please refer to his OPD surgery record in October 2014 and certificate of diagnosis on 4 November 2015.)
5. Developmental delay: According to a comprehensive evaluation of Child1 on 8 October 2015, Child1 has developmental delays in cognition, language, and motor skills, plus abnormal development of visual perception. Child1 is a Disability Card holder for moderate intellectual disability and receives occupational, physical, and speech therapy once a week. Child1 began attending a kindergarten for special education in September 2014 and will go to an elementary school in the coming September. (See the comprehensive evaluation report dated 8 October 2015)
"1. Birth History: Delivery type: NSD, GA: 39+3 weeks, birth weight: 2690g, birth length: 47cm. According to CL1’s neonatal medical record, BM was on medicine treatments during her pregnancy for hyperthyroidism, bipolar disorder and antiabortifacient.
2. CL1 visited the doctor for receiving routine vaccine and regular growth check and a carbuncle was found on right side of inner tight. Then, he was hospitalized for three days (17-19/Nov/2004).
3. According to CL1’s Physical Examination Report dated on 10th September 2015, he was in good health condition.
4. CL1 was referred to attend art therapy courses for his low frustration tolerance. He attended the therapy courses weekly from Feb/2014 to May/2014 with 13 sessions in total. This program was provided by Waldorf Education system. Children release their emotion through playing clay and watercolor painting. However, CL1 did not enjoy the program and quitted the therapy.
5. CL1 is a 5th grader attending a mainstream class.
1. Birth History: Delivery type: NSD, GA: 36+ weeks, birth weight: 2470g, birth length: 48cm.
2. According the CL2’s Physical Examination Report dated on 10th September 2015, he was in good health condition.
3. CL2 is a 1st grader attending a mainstream class.
4. When CL2 moved to Foster Family B, the foster care social worker noticed that he learned the Chinese phonetic symbols quite slowly and he was not keen to do the homework and often relied on foster mother’s assistance. Thus, according to the observation, the social worker suspected that he might have learning disability. There were some episodes happened at school and CL2 was referred to be administered psychological assessment on 7-Dec-2015. The result of the assessment revealed that the Child’s general cognitive ability is within Average range (FSIQ = 90). However, his ADHD test indicated that his ADHD scores fell within the mean scores of children with ADHD. However, this foster family disapproved of giving CL2 medical treatment. Foster mother was expecting to modify CL2’s through applying disciplinary measures firstly and waited to see the schoolteacher’s response after school began and then decided to take medicine or not.
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1. Referring to the Medical Summary dated on 12 October 2010 and issued by China Medical University Hospital, the Child’s birth history shown as follows: a premature baby with GA 36+4 weeks, birth weight: 2240 g, birth height: 44cm. The Child’s birthmother (BM) stated that she used to use heroin for five years; in addition, she took Methadone and sniffed glue for three months during pregnancy. The Child was found having neonatal abstinence syndrome, breathing difficulty, hernia and jaundice at birth and was admitted to the hospital for medical treatment. He was discharged on 12 October 2010; his NAS was over and he was well recovered after the hernia surgery. (Please refer to the Medical Summary issued by China Medical University Hospital for detail information).

2. The Child’s caregiver reported that the Child had a regular eye examination in February 2016 and was diagnosed as having amblyopia. The doctor evaluated and advised that it was caused by the brain. No surgery was necessary at that time but regular follow up was recommended.

3. The Child was performed a physical exam on 25 August 2016, referring to the Exam Report, the Child’s head circumference was 44 cm; myopia 4.0 diopters with both eyes, strabismus on the left eye, was suspected with hepatitis C. The doctor advised that the Child needed further follow up treatment. Please refer to the Child’s Physical Examination Report.

4. The Child was administered his initial developmental assessment in April 2011 and he followed up the assessment annually. He was issued the Intellectual Disability Handbook with mild level in 2015. The Child was reassessed in March 2017 and the result indicated that he was not eligible to hold the Disability Handbook. The Child’s most recent developmental assessment was administered on 23 March 2017, the results showed that the Child displayed developmental delays in cognitive functions, language development and motor skills; his cognition ability is within the Borderline range and his intra-abilities differ significantly, with FSIQ=82; he has mixed speech/language developmental delays, his environmental adaptation function ability is with Borderline range; his
vision impairment affects his sensory functions. Please refer to the Comprehensive Assessment Report dated on 2 May 2016.

The Child was assigned a therapist providing in-house therapy from the Early Intervention Education Center when he was 20 months old. After September 2014, the Child started attending kindergarten (4-year-old group) and he transferred to the Hospital for attending speech/language and occupational therapy courses once a week. The therapy courses were terminated between May and June 2016 because the Child has made progress in oral expression, and his gross/fine motor skills and cognitive functions have been comparably developed. According to his caregiver, he no longer attended therapy courses at the Hospital but he received speech/language therapy service once a month from Early Intervention Peripatetic program. The courses mainly focus on cognitive function training (introduction of daily used objects) and articulation drills to provide the Child more stimulation for his development.

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Lan, H-Y
Born December 29, 2008

1. Birth History: GA 37 weeks; birth weight: 3580 g.
2. Intellectual status: CL2 is a holder of Intellectual Disability Handbook with mild level. (Assessed in January 2015). The Psychological Assessment dated on 2nd of December 2015 indicated that CL2’s general cognitive ability is within the Average range of intellectual functioning, as measured by the Full Scale IQ (FSIQ=105, PR=63); Verbal Comprehension Index 103 (PR=58, considered as Average range); Perceptual Reasoning Index 126 (PR=96, considered as above average); Working Memory Index 103 (PR=58, considered as Average range); Processing Speed Index 89 (PR=13, considered as Low Average range).
3. ADHD: CL2 was administered Conner’s Continuous Performance Test II, the results indicated that her attention performance better matched a clinical profile (confidence index = 57.47%). She needs strong stimulations to maintain her attention. Her selective attention performance was good. She takes one tablet of Ritalin (long acting type) in the morning.
4. The Occupational Therapy Assessment Report dated on 25th of January 2016 indicated that CL2 had low proficiency of gross motor skills.
5. Psychological counseling: In February 2016, CL2 started attending psychological counseling courses once a week to help her repair the attachment relationship and cope with her traumas from her birth family.
6. Visual acuity: she has farsighted with +2.0 diopters and 1.0 astigmatism of both eyes, and she is wearing glasses for visual correction.
"1. Birth history: GA: 36+1 weeks; birth weight: 2,950g.
2. Referring to the physical examination report dated on 27th of November 2017, there were no abnormal findings except anisometropia, with big difference vision between two eyes (Left eye: 0.1; right eye: 1.2). The Child used to wear an eyepatch to correct vision; however, he thought the eyepatch influenced his appearance and tended to remove it at school. He did not apply any eye drops. In addition, the Child had a Strabismus Surgery in February 2013. (Please refer to the Out-Patient Clinic Medical Record dated on 1st of February 2013 for further information)
3. Counseling: The Child has attended psychological counseling courses in 2013 to help him process resilience for the physical abuse trauma and reestablish attachment relationship, as well as the preparation and adjustment for adoption evaluation. (Please refer to the Counseling & Guidance Summary Report dated on 16th May 2013).
4. Development: The Child was administered Joint Development Assessment and the report dated on 4th February of 2013 indicated that the Child had developmental delays in cognition ability and language skills; his performance on social emotion was suspected developmental delay. He had attended speech therapy and occupational therapy courses. His follow-up developmental joint assessment report dated on 10th of February 2014 stated that the Child was suspected of having sensory integration disorder and had developmental delay in verbal expression. The Psychological Evaluation was completed in December 2016 and it presented that the Child’s Full Scale IQ = 108, percentile rank 70 that is in the Average range. (Please refer to the Psychological Evaluation Report prepared in December 2015) On the other hand, the Special Education Evaluation Certification issued in May 2016 stated the Child suffers dyslexia. Currently, he is a 4th grader and receives academic remediation services for Chinese, English and Math courses in 1-hour sessions three times per week after school."
FOUR SIBLINGS

HSU, P-Y (CL1)
Born September 6, 2007

HSU Chin-H (CL2)
Born August 24, 2011

HSU, Chih-H (CL3)

HSU, F-H (CL4) September 23, 2014

"1. CL1 was given birth at home through natural birth. GA: 40 weeks, weighted: 2785g and had no abnormal condition when she was born. Urine occult blood was found during the medical examination in 2018; doctor told CL1 not to hold her urine for too long and to drink more water, then she will be fine. (Please view more detailed information in CL1’s Medical Summary)

2. CL1 received the handbook of mild Intellectual disability in March 2015. CL1’s teacher at school also observed that she appeared to have learning difficulties; CL1 then was diagnosed with Attention Deficit Disorder (ADD) in April 2017 and is now taking Ritalin twice a day (once in the morning and once at noon). (Please view more detailed information in CL1’s Psychological Assessment report).

3. There have been two sexual assault events occurred in January and April in the institution:
(1) Sexual assault events in January 2018 overview:
Other children in the institution randomly learnt that CL1 had inappropriate physical contact with another boy (suspect) in the institution (same age as CL1). On January 12th, 2018, the staff from the institution asked CL1 regarding the situation, the staff learnt that suspect asked CL1 to have inappropriate physical contact with him on the roof. After CL1 refused such request, suspect then took off her pants on his own. There was another incident that CL1 took off her pants on her own while with the suspect; yet, there was never any physical contact between the two. CL1 mentioned that she did not like such situation and did not feel comfortable.

Follow-up treatment: asking CL1’s special education teacher to teach CL1 how to protect herself.

(2) Sexual assault event in April 2018 overview:

On April 8th, 2018, CL1 told the institution staff that the suspect (same child) invited her to have a sexual relationship. CL1 said she refused such suggestion yet still followed the suspect to the recycling collection area and both took off their own pants; both of their genital organs had physical contact with each other but could not know for sure how long it was last. The suspect touched CL1’s right breast, then they both put their pants back on after that.

Follow-up treatment: psychological counseling sessions has been arranged for the suspect; CL1 also has been receiving psychological counseling sessions since May 16th, 2018 as well. (Please view more detailed information in CL1’s Psychological counseling summary report).

1. CL2 was born through natural birth, GA: 38+6 weeks, weighted 3100g, length: 46cm and had no abnormal condition when he was born.
2. CL2 was hospitalized on May 14th, 2016 due to seizures, which sank into unconsciousness; he was later diagnosed with Epilepsy. CL2 was discharged from the hospital on May 20th, 2016 and has not struck again since October 17th, 2016. CL2 has been taking Depakine twice a day (once in the morning and once at night). (Please view more detailed information in CL2’s discharge summary report from Min-Sheng General Hospital).
3. On July 25th, 2014, CL2 has been diagnosed with developmental delay and needs to receive early intervention sessions. As a result, CL2 started receiving physical, occupational, speech and such group therapy sessions since February 26th, 2017. (Please view more detailed information in CL2’s therapy report from Zhong Mei Hospital). Child joint development assessment was arranged on February 26th, 2017, it was found that CL2 has cognitive and perceptual-motor developmental delay. Moreover, language and social emotional development have no abnormal findings. Consequently, it was advised that CL2 needs to increase her times of repetitive learning; also, giving suitable encouragements to develop his confidence was recommended as well. (Please view more detailed information in CL2’s joint development assessment report from Taiwan Landseed Hospital).
4. CL2’s teacher from school mentioned that his handwriting seemed to be too far apart; CL2, therefore, was arranged with visual-motor integration developmental tests. CL2 fell in the range of three years and eleven months, which showed that CL2 is developmentally behind the peers of his age. (Please view more detailed information in CL2’s visual-motor integration developmental report on December 20th, 2017). Accentuated visual-motor integration training has been added in CL2’s early intervention sessions; furthermore, CL2 is now wearing nearsighted glasses. His corrected vision is 20/20.

1. CL3 was born through natural birth, GA: 36+4 weeks, weighted 2520g, length: 46cm, head circumference: 33cm, chest circumference: 31cm and had no abnormal condition when he was born. CL3’s physical examination in 2018 showed no abnormal condition either.
2. CL3 preceded his first joint development assessment on December 31st, 2014; he then was diagnosed with oral understanding and expression borderline. CL3 started receiving physical, occupational and speech therapy sessions (Please view more detailed information in CL3’s therapy treatment reports from Zhong Mei Hospital). CL3 then proceeded joint development assessment the second time on November 16th, 2017. The results showed that CL3 is suspected Intellectual disability (IQ 70), cognitive and speech developmental delay, perceptual motor borderline, but social emotional development appeared to be normal. It was advised that CL3 should actively participate in early intervention sessions and also work on his repetitive learning. Reevaluation will be arranged in October 2018. (Please view more detailed information in CL3’s joint development assessment reports from Taiwan Landseed Hospital).
3. CL4 was born through natural birth, GA: 34+1 weeks, weighted: 1680g, length: 47cm, head circumference: 31c. CL4 was hospitalized due to Respiratory distress, intrauterine growth restriction, and G6PD deficiency was suspect. CL4 was discharged from the hospital on October 8th, 2014 (Please view more detailed information in
CL4’s discharge summary report from Taipei Chang Gung Memorial Hospital). CL4 returned to the hospital for follow-ups on August 6th, 2018, G6PD test numbers appeared to be normal. CL4’s physical examination in 2018 showed no abnormal condition.

2. CL4 was diagnosed with developmental delay on October 23rd, 2015; she started receiving physical, occupational, speech and such group therapy sessions (Please view more detailed information in CL4’s therapy treatment reports from Zhong Mei Hospital). CL4 preceded joint development assessment on November 15th, 2017 and was confirmed with Intellectual disability (IQ of 60). CL4 was also diagnosed with cognitive, speech and perceptual motor developmental delay; social emotional developmental and visual-motor integration developmental boardline. It was advised that CL4 should actively participate in early intervention sessions; reevaluation will be arranged in October 2018. (Please view more detailed information in CL4’s joint development assessment reports from Taiwan Landseed Hospital)."
1. P-H was born through NSD, at 40+5 weeks gestation, with birth weight at 2574 grams, and Apgar score from 6 to 8. Due to various diseases, P-H remained at the hospital for relevant operations and treatment after birth:

Discharge diagnosis on 2014/5/20: P-H’s birth mother is a teenage mother (14 y/o). P-H has congenital heart disease characterized by RAI, DORV with pulmonary atresia, VSD, ASD, and PDA. She was small for gestational age (SGA) and passed clay-colored stools.

Discharge diagnosis on 2014/8/20: complex congenital heart disease. At the time of discharge, P-H has received the following operations: (1) PDA division; (2) mBT shunt creation; and (3) PA plasty. Biliary atresia status post Kasai operation; CVC infection, pseudomonas; and gastroesophageal reflux are also noted in the discharge diagnosis.


2. P-H was hospitalized on 2014/10/2 for gastroesophageal reflux, acute bronchiolitis with respiratory distress, and cyanosis, which was suspected to be related to mBT shunt partial occlusion. She received bidirectional cavopulmonary anastomosis, bidirectional Glenn shunt on 2014/10/8. More details in NTUH Discharge Summaries (2014/10/8, 2014/10/14, and 2014/11/7).

2015

3. P-H was admitted into hospital on 2015/1/30 because of pneumonia and acute gastroenteritis (AGE). Suspected biliary tract infection was noted in her discharge diagnosis. More details in NTUH Discharge Summary (2015/2/13).

4. P-H was hospitalized on 2015/11/20 because of having fever for 7 days with coughing and rhinorrhea. Fever, suspicious bronchopneumonia, and diarrhea were noted in her discharge diagnosis. More details in NTUH Discharge Summary (2015/11/26).

2016
5. When P-H was receiving a regular heart echo and CT scan evaluation on 2016/5/9, she was admitted into hospital after being found to have fever and feeding difficulty. Prognosis of heart disease and urinary tract infection were also noted in discharge diagnosis. More details in NTUH Discharge Summary (2016/6/2).
6. P-H was admitted into hospital due to fever on 2016/8/1. She was diagnosed with acute otitis media (right) at discharge of hospital. More details in NTUH Discharge Summary (2016/8/10)

2017
8. P-H was admitted into hospital for a routine check-up of her heart on 2017/3/1. More details in NTUH Discharge Summary (2017/3/3).
9. P-H was hospitalized on 2017/3/30 because she had suffered from fever for three days. She was diagnosed with bronchopneumonia at discharge. More details in NTUH Discharge Summary (2017/4/3).
11. P-H had total cavopulmonary connection (TCPC) on 2017/8/17. Her discharge diagnosis on 2017/9/18 included situs inversus, endocardial cushion defect (ECD), double outlet right ventricle, pulmonary atresia, atrial septal defect, and patent ductus arteriosus. At this point, she had received patent ductus arteriosus division, modified Blalock-Taussig shunt creation, pulmonary artery plasty, and modified Blalock-Taussig shunt revision with 4mm Gortex graft. More details in NTUH Discharge Summary (2017/8/26) and NTUH Discharge Summary (2017/9/18).
13. Due to her diseases, P-H has to take prescribed medicine on time. Please read the sheet of refillable prescriptions for patient with chronic illnesses issued by NTUH on 2018/8/20.

State of Development
1. First Development Assessment Report on 2016/1/27: P-H was found to have mixed developmental delays, including borderline development in cognition and mixed receptive-expressive language as well as developmental delays in gross and fine motor and swallowing function. She was issued a Disability Card for severe physical and mental disabilities in July 2016 and her identified disabilities include mental and physical developmental delays, mild endocrine system disorder (liver), and severe circulatory system disorder (heart).
2. Second Development Assessment on 2018/5/9: P-H was found to have mixed developmental delays, including borderline/suspected developmental delay of cognition, internal inconsistency of cognition, borderline/suspected delay in mixed receptive-expressive language development, and gross motor developmental delay. She is eligible to apply for a diagnosis certificate of developmental delays. Compared with her performance in the previous assessment, P-H has made steady progress in every aspect. More details in the Comprehensive Report of Child Development Evaluation Center, NTUH (2018/7/6).
3. P-H goes to the Wan Fang Development Center for school Monday through Friday."
Kao, W-C  
Born December 17, 2017

"1. BM was not aware of the pregnancy until she was sent to the emergency room due to abdominal pain; therefore, she did not follow the regular prenatal check-ups. W-C’s estimated GA was around 38+2; weight: 2970g. W-C was seizuring when he was hospitalized, which was then diagnosed as neonatal seizure. W-C’s condition was controlled by taking prescription medicine; after his condition was stabilized, he was brought home by his birth family. Please view more detailed information in the discharge summary on 2018/01/11.  
2. According to the physical examination report on 2018/06/04, W-C needed to take prescription medicine regularly for the neonatal seizure and have regulated follow-ups.  
3. Frequency of seizure episode: during the periods of 2018/01/12-18, 2018/03/16-2018/04/01, W-C was hospitalized for treatments and drug dose adjustment due to seizure episodes. W-C is now taking 0.5ml of Depakin twice a day (once in the morning and once at night), 2ml of Keppra oral solution twice a day (once in the morning and once at night) and one pack of Vimpat twice a day (once in the morning and once at night). W-C has not had an episode since April 2018 due to the drug dose adjustment. W-C had an EGG done on 2018/08/30, which showed no abnormal epileptiform activity. W-C still attends the follow-up appointments monthly. Please view more detailed information in his discharge summary and the EEG report.  
4. W-C tends to have reactive airway; he was hospitalized on 2018/04/09-2018/04/15, 2018/06/29-2018/07/03 and 2018/10/19-2018/10/29 due to pneumonia and bronchitis."

"1. GA: 38 weeks + 5; birth weight: 3600g.

2. Development: According to her psychological assessment report dated 19 December 2016, H-Y’s FSIQ is 58 (WPPSI-IV), with the ability to integrate spatial relationships as her strength. H-Y currently holds a Disability Card for mild intelligence deficiency. She is receiving special education from an itinerant teacher as well as occupational therapy and physical therapy. Since she is attending a small class (only three students in the classroom) at school, she is not studying in a resource class; the teacher will use different teaching materials for each child, depending on his or her development. (Please read the “Psychological Assessment Report” dated 19 December 2016.)

3. Heart: According to H-Y’s previous foster family care records, H-Y has a 0.32-cm patent foramen ovale (PFO) and mild mitral regurgitation (MR). When H-Y was receiving the physical exam in preparation for adoption placement, the physician said these conditions did not matter."
LI, S-W
Born September 12, 2008

"1. Referring to his Medical Summary dated on 18th of December, 2014, the Child was in good health except for elevated white blood counts. (Please refer to the Medical Summary for detailed information)
2. The Child performs normal developments in all aspects.
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1. Birth history: Child1 was delivered by NSD, his GA was unknown because BM did not have any prenatal visits during her pregnancy; birth weight: 2,840g, birth length: 53cm, Apgar score: 8/9; no abnormal findings were noticed at birth and all results of his Neonatal Screening tests were within normal range.
2. On 17-July-2018, Child1 was performed regular physical examination; and the results indicated that he had low level of blood pressure, mild anemia, and hematuria. The physician suggested that follow up at OPD was necessary. Please refer to Medical Summary dated on 17 July 2018 for detail information.
3. According to foster care social worker’s statement, Child1 suffered low-quality care and lacked of stimulation when he was under BM’s care; thus, he was suspected with developmental delays when he entered the foster care system. He was performed Psychological Assessment. The assessment results indicated that Child1’s intellectual ability was within the border line range (FSIQ =72, at 3rd percentile). In addition, he was diagnosed with ADHD and is taking Ritalin (one tablet in the morning and half tablet for school days; and only one tablet in the morning for non-school days). Please refer to the Psychological Assessment Report dated on 7 June 2017. At present, the Child’s motor skills are comparable to those of his age children and his oral expression fluency has been improved a lot.
Child1 still had impression of his original family. He understood that his mother and maternal grandmother used to be his major caregivers. He realized that BM did not take good care of him and his brother, and he was upset about that. He was aware of his background and the reason of entering the foster home. Child1 has attended psychological counseling services dates between July 14th - December 22nd, 2017 in the beginning when he was placed into the foster care system. Please refer to the Counseling / Guiding Services Closure Records prepared by TFCF (Taiwan Fund for Children and Families).
1. Referring to the Medical Summary for Child’s birth history: Child2 was delivered by NSD, GA 37 weeks; birth weight: 2,840g, birth length: 49cm, Apgar score: 8/9; the Neonatal Screening tests results indicated that Child2 had positive reaction on Short-chain acyl-CoA dehydrogenase deficiency. The second test on 14-September-2018 turned out a positive result. The doctor’s instruction to caregiver is that Child2 should eat an adequate amount of food at regular times to avoid acute symptoms triggered by hunger. Please refer to the Screening Report for detail information.
2. On 17-March-2018, Child2 was performed regular physical examination; and the result indicated that his anti-HBs was negative and he had a low hemoglobin count. Please refer to the Medical Summary dated on
17th March, 2018 for detail information. At present, Child2 is in good health condition except that he catches flus during the time of changing seasons. Child2 was performed a development assessment and the results indicated that he had developmental delays in speech skills (both receptive and expressive language), perceptual motor abilities (including gross and fine motor skills). He started attending kindergarten (for children at age 4) in August 2018; he is receiving occupational therapy services weekly. Please refer to the Comprehensive Evaluation Report dated on 9th February 2018 provided by Children Development Jointed Assessment Center of Taichung Hospital, Ministry of Health and Welfare.
"1. T-Y was born via NSD at a GA of 39+2 weeks. She was 2500 grams in weight, 47 cm in height, with a 31-cm head circumference at birth. She was diagnosed with Down syndrome. She holds a Disability Card for mild physical and mental disabilities with developmental delay and an IC Card for Severe Illness for chromosome abnormality. (more details in T-Y’s clinical record at birth)

2. T-Y received the first comprehensive evaluation of her development on 21 July 2016. The evaluation found her to have cognitive, language, and perceptual motor developmental delays, while her social and emotional development was normal. The report suggested that T-Y continue going to school and have her development tracked regularly and that her primary caregiver receive parental training to learn correct ways of caring T-Y.

3. In her second comprehensive evaluation of development on 3 May 2018, T-Y was found to have mixed developmental delays, with her overall ability at a mild-to-moderate level of developmental delay, cognition at a developmental age of 19.9 months, language at a developmental age of 15.7 months, and motor at a developmental age of 21.4 months. The developmental quotients and PRs of her cognition, language, and motor are all <54 and <1, respectively, falling in the range of moderate delays. There was no abnormality in T-Y’s social and emotional development. (more details in the Comprehensive Report by the Child Development Evaluation Center of National Taiwan University Hospital)

4. T-Y has been taking early intervention courses at the Ta Tung Child Development Center in Taipei City since September 2015."
"1. Birth history: GA 39+5 weeks; birth weight: 2,800g.
2. The Child has normal pressure Hydrocephalus and mild anemia. (Please refer to the Physical Examination Report completed in August 2017 for detail information).
3. Development: referring to the physical and mental developmental evaluation conducted on 10-June-2013, the Child was administered Bayley-III and the result indicated that the Child had intellectual disability at moderate level along with speech-language and gross motor developmental delays. In addition, according to her Individual Service Plan for year of 2016, the Child’s performance on visual, auditory and tactile functions were fair; she needed to enhance her muscle endurance and power to improve her gross motor skills; regarding her fine motor skills, she needed to continuously enhance the muscle strength of her wrists and palms/fingers. In addition, she had to improve her bathing skills. (Please refer to the ISP report for year of 2016 for detail information). The Child is a cardholder of Intellectual Disability with moderate level. She has been attending occupational, physical and language/speech therapy courses weekly and she is attending special education class in third grade year. "
1. GA: 40+3 weeks; birth weight: 3,178 grams. C-C was hospitalized immediately after birth because of Meconium aspiration syndrome, potential sepsis, hypotension, hypoxic ischemic encephalopathy, encephalomalacia, etc. She was discharged from hospital on 1 July 2015 (Please read the discharge summary of Mackay Children’s Hospital).

2. C-C was hospitalized on 21 August 2015 because of dyspnea with stridor and feeding difficulty, suspected GER, hypoxic ischemic encephalopathy, and encephalomalacia. She was discharged from hospital on 4 September 2015 (Please read the discharge summary of Mackay Children’s Hospital).

3. C-C was sent to the hospital for acute cough on 27 January 2016, but instead of going through the formalities of admitting C-C into hospital as the doctor instructed, C-C’s family took her with them as they left the hospital (Please read the ER record of Mackay Children’s Hospital).

4. Due to pervasive development disorder and acute bronchiolitis, C-C was admitted into hospital on 27 May 2016 for examination and treatment. She was discharged from hospital on 21 October 2016 (Please read the discharge summary of Cardinal Tien Hospital).

5. C-C was admitted into hospital on 12 December 2016 for an MRI because of spastic quadriplegic cerebral palsy with epilepsy. She was discharged from hospital on 13 December 2016 (Please read the discharge summary of Cardinal Tien Hospital).

6. C-C was admitted into hospital on 10 July 2017 for surgery because of cerebral palsy and severe subglottic stenosis. She was discharged from hospital on 27 July 2017 (Please read the discharge summary of National Taiwan University Hospital).

7. C-C received a comprehensive evaluation of her development after she was over 1 year old on 13 July 2016. She was diagnosed with global developmental delays because of the limitations of her physiological development.

8. C-C received the second comprehensive evaluation of her development at the age of 2 years 10 months on 6 March 2018. She has been diagnosed with infantile cerebral palsy and epilepsy. She takes Trileptal twice a day now and holds a Disability Card for mild Type 7 physical and mental disabilities. C-C can only babble as far as her language development is concerned. Her auditory response is good. In solving problems requiring visual-motor integration, C-C could shake a rattle with her left hand a little bit. Her ability of tracking an object
with her eyes is fair. Concerning C-C’s gross motor development, she is poor in head/neck control and cannot prop herself up with forearms while lying in a prone position. She is less skilled at rolling her body over and sitting with arms on support. Physical and neurological check-up finds that C-C has a small head circumference and high muscle tone in her four limbs. Brain MRI of C-C reveals old insult in bilateral frontal regions. It is therefore assessed that C-C has global developmental delays.

(1) Assessment of Gross Motor Development:
C-C’s current ability is about 0 year 3 months, with a gross motor development quotient at 41 and PR<1, indicating very poor performance and evident delay (in the range of moderate delay). C-C’s age of stationary is equivalent to 3 months (PR<1); her age of locomotion is equivalent to 4 months (PR<1). Her ability of object manipulation cannot be measured. C-C’s child development scale shows that she passes 87.5% of motor skills required for children at the developmental age of 0-2 months, 55% of motor skills required for children at the developmental age of 3-5 months, 32% of motor skills required for children at the developmental age of 6-8 months, and 0% of motor skills required for children at the developmental age of 9-11 months.

(2) Assessment of Fine Motor Development:
C-C’s current ability is about 3-5 months. Her motor control is limited by her high muscle tone. The muscle tone of her right upper limb is higher than that of the left. The fingers of her right hand only open and close slightly, so her performance in all tasks requiring bilateral movements is poor. In the test on her left side, which is her better side, C-C could try to hold a pen and draw on the paper – with the tip of the pen touching the paper and a few lines drawn. Following the therapist’s demonstration, C-C could poke the hole on a perforated board with her index finger; pull a peg out of the board but could not insert 1-2 pegs into the board; grasp an object with her thumb, index finger, and middle finger, but did not perform a pincer grasp. She could extend her hand to grasp a building block and touch it exactly (while her left hand could make it, her right hand could perform part of the movement without touching the building block). She could stare at her own hands and turn her head to track a small ball rolling from the left to the right with her eyes. She could not perform the following tasks: playing the objects in each of her hands by banging them together, transferring a toy from one hand to the other, raking the raisins on the desk with her fingers into her palm (she has performed the action, but could not move the raisins into her palm), performing pincer grasps, holding a small object with a lateral pinch, releasing a building block into a cup as shown by the therapist, stacking building blocks as demonstrated, placing a circle peg into its space on the board, and turning the pages of a hardboard book.

(3) Assessment of Sensory Integration:
Concerning C-C’s sensory registration, her motor responses were slow because of her muscle tone, so her performance could be underestimated. The evaluation finds that C-C probably has sensory integration dysfunction.

(4) Assessment of Oral Functions and Speech:
C-C’s oral movements are abnormal, so are her swallowing reflex and swallowing function. She has developmental delays in her receptive language and expressive language.

(5) Assessment of Activities of Daily Living:
C-C can chew and swallow tiny pieces of cookies and suck effectively. With assistance, she can drink from a cup without getting choked sometimes. However, she cannot hold the feeding bottle when she drinks her formula or take a tiny pellet of food with her fingers. Holding a cookie in her hand, she cannot move it precisely into her mouth. She cannot eat the food on the table as adults do (C-C still gets most of her formula via NG tube at present).
C-C does not move her arms or legs when she is being dressed or undressed. She does not know the functions of toothbrushes, combs, and towels. Her bowel movements are generally regular. She looks uncomfortable after taking a poop or pee and wants to change her diaper. She has not begun her potty training yet.
Although C-C is well-motivated to explore things, she is limited by her poor overall motor control. Given her limited play skills, C-C needs assistance to play most of the toys."
*Lin, T-E
Born May 17, 2008*

"1. Referring to the Birth Certificate, the Child’s birth weight is 3310 g and his Gestational Age is 40 weeks.  
2. The Child developed symptoms of cold while he was attending the medical examination, thus the result of chest X-ray indicated that he had suspected pulmonary infiltration on his right lower lobe of lung. The doctor reported that follow-up clinic visit is not necessary. He is developing normally and has never attended early intervention education program. (Please refer to the Physical Examination Report dated on 17-Aug-2015 for detail information). 
3. The Child has an allergic constitution; he tends to experience symptoms such as runny nose, sneezing, and asthma during seasonal changes or after taking vigorous exercise. He had an allergic asthma attack in July 2013 after he had vigorous exercise and the doctor recommended that he should take gentle to moderate exercise and change the sweaty clothes immediately to keep his body dried. He has less frequent attacks along with growing up. 
4. The Child started attending counseling course starting on 3rd May 2016 to help him develop self-identification and adoption preparation."

"
"1. Birth History: Delivery type: NSD, GA: 35 weeks, birth weight: 3000g, birth length: 48cm; no abnormal findings at birth. The physical examination performed on 23-Dec-15 indicated that the Child was underweight. (Please refer to Medical Summary for detail information).

2. Eyes: the caregiver noticed that the Child’s left eye was swollen and heavy lidded. In March 2014, the Child visited the ophthalmologist for eye examination. The eye doctor reported that the Child was suspected with drooping eyelid. The vision acuity would be affected if the eyelid droops seriously and covers the pupil of the eye. Thus, the Child needs a follow-up to assess the necessity of a surgery when she is 4 or 5 years old.

3. Brain: cerebral agenesis, there is no groove to separate her cerebral into two hemisphere and results in optic nerve atrophy, abnormal gyri development and bilateral Schizencephaly, and congenital disorder. (Please refer to Pediatric Ultrasound Report (Brain), and MRI Report of Brain for detail information) The Child is a holder of Physical and Mental Disability Handbook with profound level and Catastrophic Illness Card.

4. Developmental Delay: The Child was administered psychological development assessment on 30-Sep-2014. The results indicated that the composite scores of Cognitive, Language and Motor skills she obtained were lower than the extremely low level of norm-referenced scores. Thus, it was inferred that the Child had developmental delay within the range from sever to profound levels. Receiving rehabilitation therapy was recommended. The Child attends rehabilitation courses at Chi Mei Medical Center twice per week and in-home occupational therapy courses twice per week. Her caregivers provide her intensive self-caring skills training daily. (Please refer to the Speech/Language Assessing Record and the Summary of physical therapy assessment and services dated on 5-Oct-2015 for detail information about the Child’s development.)
"
"1. Birth History: premature birth/vaginal delivery, GA: 32 weeks+2; birth weight: 1734g was hospitalized due to newborn jaundice, Hydrocephalus on both sides of his brain and PFO (please see discharge medical record). On December 28th, 2013, no particular condition was found after an Echocardiography (ECG); therefore, SH had no need to return for further follow-up.

2. Caretaker found unusual amount of freckles on SH and then was diagnosed as Autosomal dominant disease through examination. The child also has Neurofibroma type 1 (NF1) (please see reports from 2015/04/16 and cafe-au-lait-pigmentation can be seen on his skin. The child’s conditions are mild and he is been cared as any other children. Follow-up is required annually, and the most recent follow-up was taken place on April 12th, 2016, no abnormal condition was found.

3. SH received Development assessments due to adoption preparation. On February 2nd, 2015, the child was diagnosed as cognitive developmental delay, mixed receptive-expressive language delay and find-motor skills developmental delay. SH is now receiving speech therapy and occupational therapy once per week, he is also the holder of Language Disorder manual.

4. The child’s brain structure was diagnosed as no abnormal activity through ultrasound when he was born; though the child appeared to have larger intraventricular and was later on diagnosed as thinning of the corpus callosum, which requires regular follow-ups (please see reports on 2013/12/26 and 2014/02/13). "
LO, K-T
Born December 21, 2009

"1. Birth History: delivery type: C-section; GA: 39+1 weeks; birth weight: 3260g. Please refer to Medical Summary for detail information.

2. The Child completed the Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition (WPPSI– IV). His overall cognitive ability, as measured by the FSIQ, exceed those of approximately 58% of children his age (FSIQ=103). The result of the test indicated that the Child has good learning ability. However, it was initially suspected that the Child might have sustained attention disorder. Please refer to the Psychological Report dated on 26-Sep-2016 for detail information.

3. The Child has ADHD and Reactive Attachment Disorder. He is taking medicine Concerta (two tablets) and Risperdal (0.5 tablet) per day to treat the symptoms. Please refer to the Outpatient Medical Records issued by National Taiwan University Hospital Hsin-Chu Branch dated on November 2nd, 2017.

4. The Child went for a regular physical examination on July 26th, 2017. Please refer to the Physical Examination Record dated on July 26th, 2017 for further information"
LU, H-Y
Born November 23, 2009

1. Birth History: Delivery type: Caesarean Section; GA: 41+2 weeks, Birth Weight: 2999g, Birth Height: 46.5cm; Tachypnea and Floppy were noticed at birth and the Child was diagnosed as suspected Prader-Willi Syndrome. She was born at Chung Shan Hospital; and then was transferred to Mackay Memorial Hospital for medical treatment on the 28th November 2009 and was discharged on 11th of December 2009. (Please refer to Medical Discharge Summary issued by Mackay Memorial Hospital dated on 11th December 2009).

2. The Child has Prader-Willi Syndrome. According to the Molecular Genetic Study of Chromosome Report dated on 3rd March 2014, ‘No gene deletion was found in the Child’s 15q11.1q12 region; however, two SNRPN region alleles are 100% methylated.’ In addition, the Child has intellectual disability with moderate level and is a holder of Multi-disability Handbook with moderate level.

3. The Child is suspected of having sleep apnea. (Please refer to Polysomnography Summary issued by Taipei Medical University Hospital dated on 21st March 2016 for detail information.)

4. The Child’s growth measured in August 2016: weight: 23kg at between the 50th and 75th percentile lines; height: 112cm at between 3rd and 15th percentile lines. She had follow-up visits and the doctor assessed her growth and reported that she does not need to have growth hormone injections.

5. The Child was performed an EEG test and the results showed abnormal electrical activity in the prefrontal lobe on the right side of brain but her condition did not need anti-epileptic drugs for treatment yet. (Please refer to the EEG report dated on 24th February 2016 from Neurological Department). In April 2016, the Child was prescribed cerebral cell activation medicine -- Piracetam 1ml daily to improve her cognitive functions. However, there was no significant effect and the Child only took the medicine for one week. Currently, she is not on any medications.

6. The Child was administered comprehensive developmental assessments for four times:
   (1) 9-Nov-2011: at age of 2 years, a holder of Speech & Language Disability Handbook with mild level.
   (2) 8-Oct-2013: at age of 3 years and 10 months; the Child had developmental delays in cognition ability, speech & language abilities, gross and fine motor skills and social emotions.
   (3) 22-Dec-2014: at age of 5 years and 1 month; the results were the same as prior assessment with developmental delays in cognitive functioning, speech & language abilities, gross and fine motor skills and social emotions.
   (4) 28-Dec-2015: at age of 6 years and 1 month; the Child had developmental delays in cognitive functioning, speech & language abilities, gross and fine motor skills, motor dexterity and coordination, social emotions, and attention ability; and his ability of impulsive control was within the borderline range.
1) Gross motor skills: the Child’s performances on ball skills and static / dynamic balance were at the PR of 0.1; the accuracy rate of catching beanbags was 4 out of 10 (mainly by trapping, she had difficulty in making reaction towards beanbags from different directions and speed and her hands did not move freely; stood 2 seconds on her right leg and 3 seconds on her left leg maintaining balance but with swayed body and ankles; she walked forwards alternating feet on a straight line for 1-2 meters (one foot on the line) but failed to walk heels raised along the line or walk backwards. The Child’s performance on muscle strength, endurance, postural control, and reaction is holistic insufficient. Her performances on joint range of motion, muscle tones, reflecting functioning, voluntary movement control, and gait function, etc are within normal range. The Child feeds herself independently; she needs some aids for dressing/undressing (zipping and buttoning) and cleaning herself after using toilet.

2) Fine motor skills: the Child’s fine motor performance was measured by Movement ABC-2 with percentile score 0.1. She showed right handed dominance; she posted coins into the slot with her four fingers grasp and slow speed; performed poor coordination functioning and exchanged hands frequently; she grasped bead with four finger pads but she held the thread with inappropriate finger tip pinch and performed awkward movement of threading beads, she had weak manual muscle endurance. The Child needed demonstration and guidance to follow the instructions completing the activities; she tended to be distracted and her manual and upper extremities manipulation muscle endurance was weak.

3) Language/Speech: The Child expressed her needs, feelings and refuse intention through speech, gestures and facial expression. She has developmental delay in receptive and expressive language. Most people usually could not understand her speech under in life situations only her caregiver understands. Her overall communication effectiveness was weak and her language/speech ability is within the range between age of 2 years 3 months and 2 years 9 months.

4) Psychological evaluation results:
A. Cognition development (FSIQ=40, PR<0.1), that is within the range of delays. She has difficulties in performing abilities of verbal and abstract perception reasoning and similarities, speed of visual-motor coordination, visual stimuli memory and integrating details as a whole.
B. The Child’s attention ability is within the range of delays, and her impulsivity control development is within the range of borderline. She tended to be distracted by objects in the environment settings. She frequently looked around the surroundings and literally had conversations with herself. Fortunately, she was able to cooperate with the instructions and conversations under others’ guiding and attention drawing.
C. The Child’s living adaptation ability is within the range of delays; her abilities of living adaptation skills in all aspects were all behind her age children.
D. The Child’s performance of social skills is within the range of delays; she is developing the abilities of sharing, turn taking and waiting. Usually, she tends to approach stranger too closely and has the risk of safety.
E. The Child’s emotion development is within the range delays; she tends to act out and throw tantrums when she does not get her way immediately; she refuses to process difficult tasks to express her frustration. She has difficulty express her feelings appropriately.

Intervention plans: In November 2014, the Child started attending daycare program at Wanfang Children Development Centre; in September 2015, the Child transferred to special education program at a public kindergarten. She attended occupational therapy courses at an Early Intervention Clinic after school. In January 2016, the Child’s application for 15-sessions of In-home Intervention Services. On 15th Feb of 2016, the Child transferred to attend the Daycare program at Chengzhong Development Center. In fall 2016, the Child attended special education class of first grade year at an Elementary School.
MO, H-N
Born May 10, 2010

"1. GA: 37 weeks + 5 days; birth weight: 2300g.
2. Hospitalization:
   (1) from birth to 27 May 2010: H-N was kept in the hospital for observation as a premature baby and for her flu complication.
   (2) 18 April 2011-21 April 2011: hospitalized for bronchopneumonia
   (3) 12 November 2012-19 November 2012: hospitalized for bronchopneumonia, abnormally high white blood cell count, and others
   (4) 26 November 2012-1 December 2012: hospitalized for bronchopneumonia
   (5) 14 May 2014-17 May 2014: hospitalized for acute upper respiratory infection
   (6) 12 January 2015-14 January 2015: hospitalized for constipation, gastritis, duodenitis, and others
3. Medical examinations:
   (1) Physical examination for the purpose of adoption placement:
      According to her physical exam report on 13 May 2015, H-N's head circumference is smaller and she has no local neurological deficit. Please refer to the physical exam report for details.
   (2) EEG and MRI:
      Due to H-N's frequent vomiting and stomach aches, an EEG test was arranged for her on 31 March 2015 and it revealed such abnormalities as a smaller head circumference; hence the arrangement of an MRI scan for further examination.
      The MRI scan on 14 May 2015 revealed that H-N's digestive tract and stomach showed epilepsy symptoms. H-N started taking 1 cc of Depakine, a medication to treat epilepsy, after breakfast and dinner each day since 20 May 2015. According to her foster mother (FM), H-N has not suffered any seizure since she started taking the medicine. In her return visit to the hospital in October 2015, the doctor advised that she needs to continue the medication. (Please refer to the exam reports on 13 April 2015 and 14 May 2015.)
   (3) Auditory test:
      After she failed the hearing screening at school in November 2014, H-N received an auditory brainstem response (ABR) audiometry at Mackay Memorial Hospital's Taitung Branch on 19 December 2014. It turned out that she scored 60 dB pure-tone air-conduction thresholds in her left and right ears, indicating moderate
hearing loss in her right ear and severe hearing loss in her left ear. She was issued a Disability Card for mild
hearing function disability.

H-N's pure-tone audiometry (PTA) on 15 May 2015 found that she has a moderate-to-severe level of hearing loss. According to the foster social worker, H-N has high-frequency hearing loss, meaning that she cannot hear sounds in higher frequencies. While this type of hearing loss may not cause much trouble in H-N's daily life, it will probably obstruct her learning if she goes without a hearing aid. For example, since she cannot hear sounds in higher frequencies clearly, such as sounds like ""tzu,"" ""ssu,"" and ""jih"" in Mandarin phonetics, she cannot pronounce them correctly. Since H-N began to wear hearing aids on 9 September 2015, she has been adapting well. Except for the hearing aids, H-N will also be equipped with an FM system to facilitate her learning at school in the future.

(4) Due to H-N's bedwetting problem, the foster social worker suggested in September 2012 that she receive craniosacral therapy. During a session, however, the therapist suspected a position problem in H-N's temporomandibular joint. A visit to OPD was therefore arranged for H-N in May 2013, but the doctor did not find any abnormality. H-N wets the bed less frequently now. She wets her pants sometimes only when she is nervous, feels ill, or is too absorbed in playing.

(5) H-N has signs of allergy and asthma, particularly in the change of seasons. However, she did not take anti-allergic drugs regularly in the past, because the doctor only prescribed medicine for her case by case, and her latest medicine was prescribed for her to get over the change of seasons. She has been taking Singulair at bedtime every day since 27 May 2015.

4. Current status of development:

(1) As a requirement for adoption process, H-N received an assessment of her development on 13 June 2013 and was diagnosed with mixed receptive-expressive language delay.

(2) H-N's second assessment of development on 16 July 2014 revealed that she had developmental delays in cognition, language, and motor dexterity and coordination; abnormalities in sensory integration and attention; and mild intelligence deficiency. (Please refer to the comprehensive report of Mackay Memorial Hospital's Taitung Branch.)

(3) Early intervention:

H-N has been receiving speech therapy from 26 July 2013 to date. An itinerant teacher of special education will arrive at her school irregularly to provide assistance in her early intervention. The department in charge of early intervention also provides speech therapy sessions at her school every month.

H-N receives 30 minutes of occupational therapy and physical therapy once a week at Mackay Memorial Hospital's Taitung Branch since 12 December 2014 to date"
"1. Birth History: GA: 27+5 weeks, birth weight: 1044g, cesarean delivery. The Child was found having intraventricular hemorrhage with post-hemorrhagic hydrocephalus at birth; he has been implanted the ventriculoperitoneal shunt. In addition, he was diagnosed with PDA and was performed the surgery of PDA ligation. He had been hospitalized since he was born and was discharged on 27-Nov-2013. (Please refer to the Medical Summary (dates: 5/May/13 – 27/Nov/13) prepared by Chi-Mei Hospital)

2. The Child had feeding difficulty and caused dehydration and delayed physical growth. Thus, he was hospitalized from 30/Jun/2014 to 17/Jul/2014. Moreover, he was admitted to the hospital for pneumonia medical treatment between 23 and 25 of March 2015. (Please refer to the Medical Summaries prepared by National Cheng Kung University Hospital (dates 30/Jun/2014 – 17/Jul/2014) and E-DA Hospital (dates 23-25/Mar/2015) respectively)

3. The Child had optic nerve atrophy caused by the disease of brain; he was also diagnosed with nystagmus but the eye movement has been less frequently. The Child performs visual tracking and he crawls on his belly forward to get the toys he wants to reach. His caregiver related that the Child is too young to perform a meaningful eye test; as told by the doctor the first eye exam can be performed when the Child is 3 or 4 years old.

4. The Child was administered an Inter-disciplinary Assessment on 10/Sep/2014. The result of the assessment indicated that the Child had developmental delays in cognitive ability, speech/language skills and motor functions. He had a follow-up Assessment on 16/Nov/2015 and the result indicated that the Child had global developmental delays. The therapist of Eden Early Intervention Center in Kaohsiung has been providing the Child in-home therapy weekly and the nursing staff gave the Child in-home rehabilitation daily. (For detail development information, please refer to the Comprehensive Report dated on 16/Nov/2015 prepared by E-DA Hospital Children Developmental Center, Summative Evaluation dated on 20/Nov/2015 prepared by DaShe Early Intervention Center in Kaohsiung City, and Physical Evaluation Scale Form.)

5. The Child is a CP patient with a Physical and Mental Disability Handbook in extremely severe level. The Child has low BMI and cryptorchidism on right side. (Please refer to Medical Summary dated on 28/Sep/2015)."
SHIH, C-C  
Born September 5, 2015

"1. GA: 36 weeks+2; birth weight: 2880 grams.
2. Kawasaki disease: C-C was brought to the hospital because of a fever many times while he was under the care of his birth family. The doctor diagnosed Kawasaki disease and prescribed Aspirin at that time. C-C has never sought medical treatment for a fever since he moved into Jonah House. There is no need for a follow-up either.
3. Left chronic subdural hemorrhage: An MRI study of C-C’s brain done on 13 June 2017 showed subdural hemorrhage on left frontal-parietal region, so C-C was hospitalized to undergo a Burr hole surgery for chronic SDH removal. The cause of hemorrhage was unknown. (see Discharge Summary on 24 June 2017)
4. Right upper arm hemangioma: C-C received surgical treatment to remove a hemangioma on his right upper arm on 18 March 2016. (see Discharge Summary on 18 March 2016)
5. Development: According to the comprehensive report on development dated 16 June 2017, C-C has delays in receptive language and expressive language development as well as gross and fine motor development. His age of gross motor development is 11.5 months; fine motor development, 11.6 months; receptive language development, 4.6 months; expressive language development, 5.2 months. C-C had one 1.5-hour comprehensive early intervention session (mainly occupational therapy and physical therapy) at the Early Intervention Center every week from 11 April to the end of May 2017. From 24 June to 21 November 2017, he had two 1.5-hour comprehensive early intervention sessions at a hospital every week. Currently, C-C has one speech therapy session and one occupational therapy session every week. He also holds a Disability Card for moderate disabilities (Type 1 【Developmental Delay, 1】 , Type 7 【Developmental Delay, 1】 【b765.2】 , ICD G91.9.F82 【05】 ). (see the Comprehensive Report on Assessment of Development on 13 June 2017 and Developmental Progress Form on 16 April 2018)"
TAN, M-K
Born July 11, 2007

"Birth History: GA: 40 weeks; birth weight: 2332g.

Developmental Delay: on the 1st March 2010, the Child was performed developmental assessment and the result revealed that he suffered mixed developmental delay. He is the holder of Disability Handbook for mild mental impairment. The Child started attending early education intervention daycare program in May 2010. He has mad great progress in motor skills, swallow/mouth function, verbal communication and cognitive functions. In June 2011, he was performed developmental assessment again and was revealed that he was suspected developmental delay. He just needed to follow-up his development. In September 2011, he started attending kindergarten regular program and then he was discharged the early education intervention program. In November 2011, the Government Social Worker related that the Child would be performed physical and mental disability assessment (for Disability Handbook) next year and the Doctor reported that the Child might not be eligible as the holder of the Disability Handbook. However, on 19th January 2012, the Speech Language Pathologist from Cathwel Service performed the assessment for the Child and found that the Child displayed poor cognitive ability and advised him receiving related training.

Polydactyly: The Child had an extra digit on the right hand of radial side and was removed in August 2008. Currently, his right thumb bends most of the time and rarely makes functions. He is a right-handed person but his right hand does not function well. Thus, he uses both hands to manipulate things. The Doctor reported that the function of his right thumb is not possible to recover normally. It is important to give it massage to avoid atrophy.

Physical Health: According to the physical exam report dated in November 2010, the Child suffered developmental delay, mild thoracic curve, and poor muscle strength of his right hand. Regarding the thoracic curve issue, the Government Social Worker reported that there was no abnormality then never follow up."

"
"1. GA: 40 weeks plus 2 days; birth weight: 3000 grams
2. DiGeorge syndrome: M-H was diagnosed with DiGeorge syndrome after birth. Currently, he has to take calcium supplementation and check his serum calcium value and hearing at the hospital every three months. M-H takes one Calcium acetate tablet and one Calcitriol tablet in the morning and in the evening every day. He holds a Disability Card for severe disability (rare disease) (please refer to his discharge summary dated 30 March 2011).
3. Developmental delays: According to a comprehensive assessment report on M-H’s development dated 2 November 2016, M-H’s cognitive, receptive language, and expressive language development falls in the borderline range. He is currently studying in a day-care class of the Early Intervention Center and receiving occupational, physical, and speech therapy at school (Please read the comprehensive assessment report on development dated 2 November 2016). "
TSAO, J-H
Born May 9, 2017

"1. Birth history: Delivery type: NSD, Gestational week: 39 weeks, birthday weight: 3,030g, birth length: 50cm. The Child was performed a newborn physical examination and was found having HBsAg positive. The recheck was performed on the 16th of November and the result was HBsAg negative. Please refer to the Medical Summary and the Report of Hepatitis B test result.

2. The Child was underwent a brain echo and an EEG on 15-Dec-2017. The result of EEG verified that the Child had Seizure / Infantile spasm. After that, he started taking Vigabatrin (tablet-500mg) (twice a day, 1 tab in the morning and 1 tab in the evening) and Pyridoxine (Vitamin B6) tablet-50mg, once 3 tablets per day. The medication effect will be continuously monitored and adjusted to fit his conditions. The MRI of brain performed on 27-Dec-2017 indicated that the Child has delayed myelination milestone in the right frontal and temporal lobes as well as mild ventricular dilatation and relatively prominent CSF space. Please refer to the examination report of Brain Echo, EEG and MRI for detail information."
Referring to the Physical Examination Report dated on 18th August 2014, the Child was in good health. However it was noted that there were many burns and bruises all over his body. The social worker asked the Child about the scars and learned that the burns were cigarette burns made by a family friend. The Child related that he got food after he suffered the cigarette burns and thought it was not bad at all. Regarding the bruises, it was caused by MGM’s partner’s beating.

"
WANG, Y-H
Born November 1, 2008

"1. Y-H was born through natural birth; GA: 39 weeks, weighted 3036g, apgar score of 8 to 9. When Y-H was born, she had Cyanosis with respiratory distress and respiratory acidosis, Hyperbilirubinemia / phototherapy, Moderate mitral regurgitation and Mild tricuspid regurgitation and patent foramen ovale. Please view more detailed information in the discharge summary on 2008/11/08.

2. Y-H had a physical examination on 2017/09/27 and showed no abnormal results. Please view more detailed information in the Medical Summary.

3. Y-H had a psychological assessment in 2015; the results showed that she was slightly delayed in intelligent performance (FSIQ=71). Y-H then had another psychological assessment in 2017, her intelligent performance then showed normal (FSIQ=93). Please view more detailed information in the psychological assessment referral sheet on 2017/09/25.

4. Psychological assessment: Y-H started proceeding play therapy every week since May 2018 for her family background and self-understanding."
WU, C-C
Born November 19, 2008

"1. Birth History: Delivery type: NSD; GA: 35+2 weeks; birth weight: 2500g; height: 47cm. The Child had no abnormal findings at birth. (Please refer to the Child’s Birth History Medical Summary)
2. The Child was performed a physical examination and had no abnormal findings from the report. (Please refer to the Medical Summary dated on 24 May 2016). According to the Chief Social Worker, the Child had a medical history of scabies but has been cured. In addition, he has Atopic Dermatitis and tends to have dry and itchy skin during the change of seasons and using moisturizer would relieve the symptoms. Currently, he is free from the symptoms.
3. The Child had a surgery for Cryptorchidism on 16 October 2014. He has fully recovered from the symptom and did not need special treatment. (Please refer to the surgery record summary).
4. Development and Psychological Assessment:
   (1) The Child was administered developmental assessment when he was about to turn five years old. The result revealed that he had developmental delays in mix-language skills, cognition abilities and fine motor skills. In March 2014, the Child was the holder of Intellectual Disability Handbook with moderate level. After that, his foster carer has assisted taking the Child to attend occupational and speech/language therapy courses.
   (2) On 27 November 2014, the Child was administered an assessment. The result indicated that he had suspected developmental delays in expressive language, gross motor skills and social emotions; and had developmental delays in cognition. His performance of cognitive ability was in the Mild range of intellectual disability and his Disability Handbook was revised as Mild level. The next follow-up assessment was scheduled in the end of 2016.
   (3) On 18 March 2015, the Child was administered psychological assessment; the result indicated that the Child’s performance of attention deficit and impulsive behavior reached the clinically significant level. (Please refer to Report of Psychological Assessment / Treatment issued by Seed Of Hope Clinic). The Child moved to current foster family after the assessment, current foster carers provide great caring service to the Child, and he never has a follow-up visit for the related issues and never takes medicine for hyperactivity.
The Child has been attending speech/language therapy and occupational therapy courses once per week at Minsin Children's Development Center since July 2015. He was supposed to start attending elementary school in the same year but he deferred entry due to his learning ability was quite behind his age peers. In September 2016, the Child started attending regular classes of first grade year. He has been attending the occupational, physical and speech/language therapy courses provided by the resource classes of the Elementary school two days per week after school.

5. The Child completed four stages of counseling courses as follows (Please refer to the Counseling Therapy Report Summary for detail information):
   Stage I & II (20 sessions) : November 2014 to August 2015
   For coping with the Child's psychological traumas caused from his childhood abuse experiences and the unexpected separation with his first foster family.
   Stage III: November 2015 to January 2016
   For assisting the Child developing his self-identification and adoption preparation.
   Stage IV: March 2016 to August 2016
   To help the Child stabilize his living and develop his self-confidence.

6. History of physical abuse record:
   (1) According to the record from Taipei City Center for Prevention of Domestic Violence and Sexual Assault (DVSA), they received a report on 11 September 2013 that the Child pointed out his injuries and told his caregiver (at Oasis Home) that his uncle tied his hands. There were significant purple marks left on his wrists, bruises on his cheek below his left eyes and some lumps and scrapes on his left forehead. The doctor checked and confirmed that his injury was caused by external forces.
   (2) DVSA received a report on 23 May 214 that the Child was suspected suffering maltreatment at the foster home and caused some bruises on his wrists. After investigating, it could not be verified that the Child’s foster carer did it.
WU, C-Y  
Born September 1, 2014

"1. GA: 36+4 weeks; birth weight: 3060 grams
2. C-Y received medical treatment for SDH over bilateral F-T-P regions in October 2014 and was subsequently diagnosed with chronic subdural hematoma, seizure, brain atrophy with ventriculomegaly, and suspected bilateral impairment of hearing ability. According to C-Y’s caregivers, C-Y has not had a seizure since she was 1.5 years old; however, she still takes antiepileptic drugs regularly (Sabril, one tab in the morning and evening, respectively; Trileptal, 1 ml in the morning). In addition, the doctor has prescribed BEESIX 50 mg (vit B6), two tablets in the morning and evening, respectively; and demanded tracking C-Y’s brain wave patterns at the department of neurology once a month. As for C-Y’s hearing, the caregiver says she has 40 dB HL in the left ear and 20 dB HL in the right ear at present. A follow-up examination of her hearing is required every six months. (Please read the discharge summary dated 6 January 2015, and EEG and DPOAE reports dated 22 July 2016 and 26 October 2017 for details.)
3. C-Y was hospitalized for acute bronchiolitis in March 2016. Please read the discharge summary dated 4 April 2016.
4. Development: According to the report on comprehensive assessment of development dated 8 April 2015, C-Y had cognitive, motor, and social and emotional developmental delays and was suspected of sensory developmental delay. Her language development was not assessed. On the Bayley-III test, C-Y scored 55 for her cognitive development and 46 for her motor development; both scores indicate 1-2 months of developmental age. On the PDMS-II test, C-Y’s gross motor score was <1% and her fine motor developmental quotient was below average (the average quotient was 46). C-Y took two comprehensive early intervention sessions every week during the time from 2015 to June 2017 and three comprehensive early intervention sessions every month from July to December 2017. She stopped taking her early intervention sessions due to her transfer to a new placement institute. She is expected to resume early intervention sessions after June 2018. C-Y is currently holding a Disability Card for extremely severe disabilities (【b110.4】，【b710a.2】，【b710b.2】，and ICD 348.3【09.05】)"
YANG, M-H
Born September 14, 2008

1. GA: 40 weeks; birth weight: 2960 grams.
2. Cortical dysplasia on the left side of the brain: A certificate of diagnosis issued by the National Taiwan University Hospital in December 2015 confirms that M-H has cortical dysplasia on the left side of his brain, with epileptiform discharges in his EEG study; follow-up examinations are required. Nevertheless, M-H has never had an epileptic seizure under the care of his foster family. M-H's right limbs (arm and leg) are weaker and one of his legs is longer than the other. However, he has no trouble walking and running. He has a Disability Handbook for mild disabilities (Type 7 【b730a.1】; ICD codes 742.4, 343.9 【05】).
3. Development: According to a comprehensive evaluation report in January 2014, M-H had articulation disorder and gross and fine motor developmental delays and began receiving speech therapy, occupational therapy, and physical therapy. He stopped receiving physical therapy and speech therapy in August and October 2015, respectively, because he had caught up with children his age in development. Currently, M-H has three sessions of occupational therapy every week to improve his physical development. (see the comprehensive evaluation report in January 2014 and occupational therapy report for details.)
"1. GA: 40 weeks, birth weight: 2,675g.
2. Y-W had a physical examination on May 24th, 2018, it was resulted in urine occult blood positive, stool occult blood positive and pulmonary infiltrates.
3. Development: according to the Joint assessment report on March 21st, 2018, Y-W is delayed in fine motor skills, language, cognitive, emotion and social adaption developments. She is also suspected in gross motor skills delay, along with Sensory Integration Dysfunction, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD)/ Attention Deficit Disorder (ADD). Y-W is a holder of the physically and mentally mild disability card (Type 1 [b117.1][b122.1], diagnosis of ICD: F34.0[11]); Y-W is also a holder of Catastrophic Illness Card for Autism. Y-W is now attending speech and occupational therapy once a week; she is now also taking one Ritalin and half of an Aripiprazole per day. (Please view more detailed information on the assessment report on March 21st, 2018)
4. Psychological counseling: Y-W started receiving play therapy since January 2017 (once a week); the purpose of receiving play therapy is mainly focused on assisting Y-W to process and cope with her emotions.

1. GA: 40 weeks, birth weight: 2,850g.
2. W-L had a physical examination on May 24th, 2018, it was resulted in low hemoglobin, urine occult blood is weakly positive and pulmonary infiltrates.
3. Development: according to the Joint assessment report on September, 2016, W-L was diagnosed with mixed speech and fine motor skills delayed, then was furthermore being diagnosed with Global Developmental Delay (includes speech, motor skills, cognitive delay ). Ever since W-L was diagnosed with developmental delay, early intervention was provided right away, which including speech, cognitive, physical and occupational therapy. Nevertheless, W-L was transferred to another foster family in June 2018; thus, early intervention sessions were temporarily discontinued. W-L will be reevaluated at the end of the year, and then early intervention sessions will be rearranged once again. (Please view more detailed information on the assessment report on September 19th, 2017)."