Tuberous Sclerosis Complex (TSC) is associated with a range of neuropsychiatric disorders which we refer to as TAND (TSC–Associated–Neuropsychiatric–Disorders). All people with TSC are at risk of having some of these difficulties. Some people with TSC have very few, while others will have many of them.

Each person with TSC will therefore have their own TAND profile, and this profile may change over time. This checklist was developed to help clinical teams, individuals with TSC and their families a) screen for TAND at every clinic visit and b) prioritize what to do next.

Instructions for use
The TAND Checklist was designed to be completed by a clinician with relevant knowledge and experience in TSC, in partnership with individuals with TSC or their parents/carers. The Checklist should take about 10 minutes to complete.

Where individuals answer YES to an item, the clinician should explore the difficulty in sufficient detail to help guide decisions about further evaluation or treatment. All items should be completed.

About the interview
Name of TSC Subject:.......................................................... DOB: d m y Age: □
Name of Interviewer: .......................................................... Date of interview: d m y □ □
Name of interviewee: .......................................................... Self / Parent / Carer / Other (circle)

01 Let’s begin by talking about [subject]’s development to get a sense of where they are at. How old was [subject] when he/she:

a. First smiled?
   Age: □ Not yet: □

b. Sat without support?
   Age: □ Not yet: □

c. Walked without holding on?
   Age: □ Not yet: □

d. Used single words other than “mama” or “dada”?  
   Age: □ Not yet: □

e. Used two words/short phrases?
   Age: □ Not yet: □

f. Was toilet trained during the day?
   Age: □ Not yet: □

g. Was toilet trained at night?
   Age: □ Not yet: □
### What is [subject]’s current level of (please tick):

<table>
<thead>
<tr>
<th>a. Language:</th>
<th>non-verbal</th>
<th>simple language</th>
<th>fluent</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Self-care:</td>
<td>dependent on others</td>
<td>some self-care skills</td>
<td>independent</td>
</tr>
<tr>
<td>c. Mobility:</td>
<td>wheelchair</td>
<td>needs significant support</td>
<td>some difficulty</td>
</tr>
</tbody>
</table>

### Let’s talk about behaviors causing concern to you or to other people. Have/has [subject] ever had difficulty with any of the following?

| a. Anxiety             | NO         | YES          |
| b. Depressed mood      | NO         | YES          |
| c. Extreme shyness     | NO         | YES          |
| d. Mood swings         | NO         | YES          |
| e. Aggressive outbursts| NO         | YES          |
| f. Temper Tantrums     | NO         | YES          |
| g. Self-injury, such as hitting self, biting self, scratching self | NO | YES |
| h. Absent or delayed onset of language to communicate | NO | YES |
| i. Repeating words or phrases over and over again | NO | YES |
| j. Poor eye contact    | NO         | YES          |
| k. Difficulties getting on with other people of similar age | NO | YES |
| l. Repetitive behaviors, such as doing the same thing over and over again | NO | YES |
| m. Very rigid or inflexible about how to do things or not liking change in routines | NO | YES |
| n. Overactivity/hyperactivity, such as being constantly on the go | NO | YES |
| o. Difficulty paying attention or concentrating | NO | YES |
| p. Restlessness or fidgetiness, such as wriggling or squirming | NO | YES |
| q. Impulsivity, such as butting in, not waiting turn | NO | YES |
| r. Difficulties with eating, such as eating too much, too little, unusual things | NO | YES |
| s. Sleep difficulties, such as with falling asleep or waking | NO | YES |

If you answered YES to any of the above:

| Have you had further evaluation or support for it? | NO | YES |
| Would you like to have further evaluation or support for it? | NO | YES |

### Problem behaviors may add up to meet criteria for specific psychiatric disorders. Have/has [subject] ever received a diagnosis of:

| a. Autism Spectrum Disorder (ASD), including autism, Asperger’s | NO | YES |
| b. Attention Deficit Hyperactivity Disorder (ADHD) | NO | YES |
| c. Anxiety Disorder, including as panic, phobia, separation anxiety disorder | NO | YES |
| d. Depressive Disorder | NO | YES |
| e. Obsessive Compulsive Disorder | NO | YES |
| f. Psychotic Disorder, including schizophrenia | NO | YES |

If you answered YES to any of the above:

| Have you had further evaluation or support for it? | NO | YES |
| Would you like to have further evaluation or support for it? | NO | YES |
About half of people with TSC will have significant difficulties in their overall intellectual development and may have ‘intellectual disability’.

a. Have you ever been concerned about this for [subject]?
   - NO □  YES □

b. Have/has [subject] ever had a formal evaluation of intelligence by a professional using IQ tests?
   - NO □  YES □
   If YES, what did results show?
   - Normal Intellectual Ability (IQ > 80)
   - Borderline Intellectual Ability (IQ 70-80)
   - Mild Intellectual Disability (IQ 50-69)
   - Moderate Intellectual Disability (IQ 35-49)
   - Severe Intellectual Disability (IQ 21-34)
   - Profound Intellectual Disability (IQ <20)

c. What is your view of [subject]’s intellectual ability?
   - Normal Intellectual Ability
   - Mild-Moderate Intellectual Disability
   - Severe - Profound Intellectual Disability

d. Would you like to have further evaluation or support for it?
   - NO □  YES □

Many people with TSC who are of school age will have difficulty in school.

[For individuals of school age]: Does/do [subject] have any difficulty with any of the following:
[For individuals after school age]: Did [subject] have any difficulty with any of the following:

a. Reading
   - N/A □  NO □  YES □

b. Writing
   - N/A □  NO □  YES □

c. Spelling
   - N/A □  NO □  YES □

d. Mathematics
   - N/A □  NO □  YES □

If you answered YES to any of the above
Have/has [subject] had further evaluation or support for it?
   - NO □  YES □
Have/has [subject] been considered for any additional support in school such as extra help or an Individual Educational Plan (IEP)?
   - NO □  YES □
Would you like to have further evaluation or support for [subject]?
   - NO □  YES □

The majority of people with TSC will have some difficulties in some specific brain skills. Do/does [subject] have difficulty with any of the following:

a. Memory, such as remembering things that have happened
   - NO □  YES □

b. Attention, such as concentrating well, not getting distracted
   - NO □  YES □

c. Dual-tasking/ Multi-tasking, such as doing 2 tasks at the same time
   - NO □  YES □

d. Visuo-spatial tasks, such as solving puzzles or using building blocks
   - NO □  YES □

e. Executive skills, such as planning, organizing, flexible thinking
   - NO □  YES □

f. Getting disoriented, such as not knowing the date or where you are
   - NO □  YES □

If you answered YES to any of the above
Have/has [subject] had further evaluation or support for it?
   - NO □  YES □
Would you like to have further evaluation or support for these difficulties?
   - NO □  YES □
Apart from the challenges listed above, TSC can have a big impact on people's lives in other ways. Have/has [subject] had any difficulties with:

a. Low self-esteem
   NO □ YES □

b. Very high levels of stress in families, for instance between siblings
   NO □ YES □

c. Very high levels of stress between parents leading to significant relationship difficulties
   NO □ YES □

If you answered YES to any of the above
Have/has [subject] and/or your family had further evaluation or support for it?  
NO □ YES □

Would you like to have further evaluation or support for it?  
NO □ YES □

Taking together all the difficulties discussed above, how much have these bothered, troubled or distressed you/your child/family?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

Of all the concerns listed above, what are your top priorities to work on next?

a. ..............................................................................................................................................................................................................
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b. ..............................................................................................................................................................................................................
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c. ..............................................................................................................................................................................................................
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Do you have any other worries about TAND for [subject] that we have not talked about as we went through the checklist?
NO □ YES □ If YES, please list:
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Interviewer's judgment of impact/burden on the individual/child/family.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

Thank You!