



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF MEDICAL SERVICES
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
18-23 MONTHS

DATE	NAME		DATE OF BIRTH	
MEDICAID NUMBER			MEDICAL RECORD NUMBER	
TEMP	RR	HEIGHT	%	ALLERGIES <input type="checkbox"/> NKDA
PULSE	HEAD CIRC	WEIGHT	%	MEDICATIONS <input type="checkbox"/> NONE

I. INTERVAL HISTORY/PARENT'S CONCERNS:

Chronic Illnesses: _____ ER/Hospital utilization since last visit

Triggers reviewed: _____

Medications changed/refilled: _____

Education Consult/Referral

Naps: _____

Activity: _____

Child Care: _____

Injuries: _____

Family High Risk Factors: _____

Nutrition: Milk: _____, _____ oz/feeding _____ times per day **WIC Referral**

Solid food (encourage all food groups: _____)

Output: Urine: _____ Stools: _____

Diaper Rash: _____

COMMENTS

II. UNCLOTHED PHYSICAL EXAM: Check Growth Chart

SYSTEM	NL	CHECK ABNORMALS AND COMMENT	COMMENTS
General		<input type="checkbox"/> Alert <input type="checkbox"/> Active <input type="checkbox"/> NAD	
Skin		<input type="checkbox"/> Pink <input type="checkbox"/> Well perfused <input type="checkbox"/> No rash	
Head		<input type="checkbox"/> NC <input type="checkbox"/> Ant font soft flat	
Eyes		<input type="checkbox"/> PERRL <input type="checkbox"/> + Red Reflexes R / L / B	
Ears		<input type="checkbox"/> Pinna WNL <input type="checkbox"/> Position WNL <input type="checkbox"/> TM clear R / L / B	
Nose		<input type="checkbox"/> Nares patent <input type="checkbox"/> Septum Midline	
Oropharynx		<input type="checkbox"/> Palate intact <input type="checkbox"/> Uvula midline <input type="checkbox"/> Uvula single	
Neck		<input type="checkbox"/> Supple <input type="checkbox"/> No masses <input type="checkbox"/> No thyromegaly	
Lungs		<input type="checkbox"/> CTA <input type="checkbox"/> BS = <input type="checkbox"/> No retractions <input type="checkbox"/> No stridor	
Heart		<input type="checkbox"/> RRR <input type="checkbox"/> No murmur	
Pulses		<input type="checkbox"/> Femoral 2+/4= <input type="checkbox"/> Brachial 2+/4=	
Abdomen		<input type="checkbox"/> Soft <input type="checkbox"/> Non-tender <input type="checkbox"/> +BS <input type="checkbox"/> No HSM <input type="checkbox"/> No masses	
Back		<input type="checkbox"/> Straight spine <input type="checkbox"/> Intact spine	
GU		<input type="checkbox"/> NL ext. Male <input type="checkbox"/> No hypospadias <input type="checkbox"/> Descended testes R / L / B	
Skeletal		<input type="checkbox"/> Moves all extremities = <input type="checkbox"/> NL structure <input type="checkbox"/> NL tone <input type="checkbox"/> NL strength <input type="checkbox"/> FROM	
Neuro		<input type="checkbox"/> Responds to Stimuli <input type="checkbox"/> CN 2-12 grossly intact <input type="checkbox"/> Patellar DTR 2+/4=	

SIGNATURE	DATE
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FULL SCREEN (I-X)	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	HEARING SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>
PARTIAL SCREEN (1-V)	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	VISION SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>
DEVELOPMENTAL SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	DENTAL SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>

III. ANTICIPATORY GUIDANCE (Check at least 1 item in this category)

<input type="checkbox"/> Active playing	<input type="checkbox"/> Street safety	<input type="checkbox"/> Television	<input type="checkbox"/> Exercise	COMMENTS
<input type="checkbox"/> Peer play	<input type="checkbox"/> Water safety/pools	<input type="checkbox"/> Toilet training		
<input type="checkbox"/> Biting	<input type="checkbox"/> Balloon/plastic bag safety	Feeding:		
<input type="checkbox"/> Consistent limits	<input type="checkbox"/> Hot/Cold	<input type="checkbox"/> 3 meals with snacks		
<input type="checkbox"/> General curiosity	<input type="checkbox"/> Water heater temperature (<130 F)	<input type="checkbox"/> Variety of food		
<input type="checkbox"/> Matches, lighters	<input type="checkbox"/> Bathtub safety	<input type="checkbox"/> Junk food		
<input type="checkbox"/> Knives	<input type="checkbox"/> Toddler car seats/Airbags	<input type="checkbox"/> Pica		
<input type="checkbox"/> Reading to child	<input type="checkbox"/> Ingestions/lpecac	<input type="checkbox"/> Variable appetite		
<input type="checkbox"/> Parental smoking	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Self feeding		

IV: LAB/IMMUNIZATIONS: Labs: Blood lead level (if not done previously) Other _____

Immunizations given today: _____
 UTD Written information given Consent signed (Follow the recommended immunization schedule approved by the ACIP, AAP, and AAFP)

V. LEAD SCREEN Lead Assessment Guide complete Negative screen Positive screen - draw blood lead level

VI. DEVELOPMENT PERSONAL-SOCIAL AND LANGUAGE: **Parents as teachers referral** (Check at least 1 item in this category)

Minimal Skills	<input type="checkbox"/> Helps in house - R	<input type="checkbox"/> Drinks from cup - R	Emerging Skills	COMMENTS
<input type="checkbox"/> Dada/Mama specific - R	<input type="checkbox"/> Imitates activities - R	<input type="checkbox"/> 15-20 words	<input type="checkbox"/> Imitates words	
<input type="checkbox"/> One word - R	<input type="checkbox"/> Two words - R	<input type="checkbox"/> 2-word phrases	<input type="checkbox"/> Follow directions	
		<input type="checkbox"/> Name objects	<input type="checkbox"/> Spoon and cup	
		<input type="checkbox"/> Listen to story	<input type="checkbox"/> Name body parts	
			<input type="checkbox"/> Look at pictures	

VII. FINE MOTOR/GROSS MOTOR: (Check at least 1 item in this category)

Minimal Skills	<input type="checkbox"/> Walks well	<input type="checkbox"/> Scribbles	Emerging Skills	COMMENTS
<input type="checkbox"/> Bangs 2 cubes in hands - R	<input type="checkbox"/> Puts block in cup	<input type="checkbox"/> Stacks 3-4 blocks	<input type="checkbox"/> Runs	
<input type="checkbox"/> Walks backward - R	<input type="checkbox"/> Stoops and recovers	<input type="checkbox"/> Imitates scribbles	<input type="checkbox"/> Pulls toy	
		<input type="checkbox"/> Walks quickly		

VIII. HEARING: (Check at least 1 item in this category)

- Parental perception of hearing
- Awakes to loud noise
- Head turning with noise
- Ear exam with pneumatic otoscope
- Observational screening with noisemaker
- ERA/ABR screen for infant in tertiary care > 5 days
- Family history of hearing disorders
- PMHx: NICU admission/ ear infection/ head injury/ congenital anomalies/ meningitis/ mumps/ cerebral palsy
- Tympanometry
- 3-4 words other than "Mama", "Dada" Repeats sound

COMMENTS

IX. VISION: (Check at least 1 item in this category)

- Parental perception of vision
- Observation for blinking Cover test
- pupillary response Enjoys short books, bright pictures
- red reflex/fundus tracking
- ocular movements
- Family history of visual disorders
- Attempts to pick up small objects, bits of food
- PMHx: NICU admission/ prolonged oxygen administration

COMMENTS

X. DENTAL Teeth brushing by parents

- Normal tooth eruption times Teething behavior
- Assess teeth development and oral hygiene - Teeth cleaning
- Fluoride supplements if water fluoridation less than 0.7 ppm

NOTE: It is recommended that assessment preventive dental services and oral treatments for children begin at age 6-12 months and be repeated every 6 months or as medically indicated.

COMMENTS

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____