

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"/> Sleeping problems	<input type="checkbox"/> Traffic hazards	<input type="checkbox"/> Pre-kindergarten	COMMENTS
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Water safety/pools	<input type="checkbox"/> Sun Exposure	
<input type="checkbox"/> Cursing	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Parental smoking	
<input type="checkbox"/> Stuttering	<input type="checkbox"/> Fire safety	<input type="checkbox"/> Smoke detector	
<input type="checkbox"/> Discipline/Time out	<input type="checkbox"/> Matches, lighter safety	Feeding:	
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Bicycle helmet	<input type="checkbox"/> 3 meals with snacks	
<input type="checkbox"/> Television/Exercise	<input type="checkbox"/> Car seat/Airbags	<input type="checkbox"/> Variety of food	
<input type="checkbox"/> Reading to child	<input type="checkbox"/> Ingestions/poisons	<input type="checkbox"/> Proper amounts	

IV. LAB/IMMUNIZATIONS: Labs: Blood lead level (if not done previously at 24 months) 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	Emerging Skills	COMMENTS	
<input type="checkbox"/> Names four pictures	<input type="checkbox"/> Name, age, sex		<input type="checkbox"/> 3 adjectives
<input type="checkbox"/> Puts on clothes -R	<input type="checkbox"/> Awareness of gender		<input type="checkbox"/> ≥ 4 colors
<input type="checkbox"/> Feed doll	<input type="checkbox"/> Discuss activities		<input type="checkbox"/> Pronouns/plurals
<input type="checkbox"/> Brush teeth with help - R	<input type="checkbox"/> Past tense		<input type="checkbox"/> 3 word sentences
<input type="checkbox"/> Speech mostly understandable	<input type="checkbox"/> Brush teeth without help		

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

Minimal Skills	Emerging Skills	COMMENTS	
<input type="checkbox"/> Jumps up	<input type="checkbox"/> Stacks 10 blocks		<input type="checkbox"/> Picks longer line
<input type="checkbox"/> Stacks 6 cubes	<input type="checkbox"/> Jumps in place		<input type="checkbox"/> Copies circle/cross
<input type="checkbox"/> Throws ball overhand	<input type="checkbox"/> Dress without help		<input type="checkbox"/> Draw person - 3 parts
<input type="checkbox"/> Kicks ball forward	<input type="checkbox"/> Balances on 1 foot for 3-5 seconds		<input type="checkbox"/> Rides tricycle

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

- Parental perception of hearing
- 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
- Identifies familiar pictures
- Names desired objects (candy, juice)

COMMENTS

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

- Parental perception of vision
- Observation for blinking ocular movements
- pupillary response tracking
- Objective testing including Snellen E, distance acuity, and light reflex/cover test
- Exam of external eye, fundoscopic exam
- Family history of visual disorders
- Eye injuries, foreign substances
- PMHx: NICU admission/ prolonged oxygen administration

COMMENTS

X. DENTAL Dental referral for complete diagnostic work-up

- Teeth brushing by parents Normal tooth eruption times
- 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 _____