

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"/> Loss of appetite <input type="checkbox"/> Discipline <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Strangers <input type="checkbox"/> Child-proofing cords, electrical sockets, plants, stairs <input type="checkbox"/> Reading to child <input type="checkbox"/> Stimulation <input type="checkbox"/> Parental smoking	<input type="checkbox"/> Choking hazards - nuts, popcorn, hotdogs <input type="checkbox"/> Safe walkers <input type="checkbox"/> Stair guards <input type="checkbox"/> Crib safety <input type="checkbox"/> Co-sleeping <input type="checkbox"/> Water heater temperature (<130 F) <input type="checkbox"/> Bathtub safety <input type="checkbox"/> Car seats/Airbags <input type="checkbox"/> Poisons <input type="checkbox"/> Smoke detector	<input type="checkbox"/> Acetaminophen dose <input type="checkbox"/> Ipecac Feeding: <input type="checkbox"/> Iron/Vitamins <input type="checkbox"/> Breast-feeding support <input type="checkbox"/> Weaning to cup <input type="checkbox"/> Intro to new foods, cereals, vegetables, fruits, meats <input type="checkbox"/> Mashed table food	COMMENTS
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IV: LAB/IMMUNIZATIONS: Labs: _____

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"/> Spontaneous smile - R <input type="checkbox"/> Feeds self - R <input type="checkbox"/> Works for toy <input type="checkbox"/> Regards own hand - R <input type="checkbox"/> Single syllables - R <input type="checkbox"/> Imitates speech sounds <input type="checkbox"/> Turns toward voice	Emerging Skills <input type="checkbox"/> Responds to name <input type="checkbox"/> Waves bye-bye <input type="checkbox"/> Interactive games <input type="checkbox"/> Indicates wants <input type="checkbox"/> Stranger anxiety <input type="checkbox"/> Drinks from cup <input type="checkbox"/> Mama/dada, specific <input type="checkbox"/> 1-2 additional words	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check at least 1 item in this category)

Minimal Skills <input type="checkbox"/> Looks for yarn/object <input type="checkbox"/> Stands, holding on <input type="checkbox"/> Rakes raisin <input type="checkbox"/> Pulls to sit, no head lag <input type="checkbox"/> Passes cube <input type="checkbox"/> Sits without support	Emerging Skills <input type="checkbox"/> Inferior pincer grasp <input type="checkbox"/> Stands 2 seconds <input type="checkbox"/> Bangs two blocks <input type="checkbox"/> Probes with fingers <input type="checkbox"/> Holds bottle <input type="checkbox"/> Puts block in cup <input type="checkbox"/> Gets to sitting position <input type="checkbox"/> Crawls <input type="checkbox"/> Pulls to stand/cruises	COMMENTS
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VIII. HEARING: (Check at least 1 item in this category) <input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Awakes to loud noise <input type="checkbox"/> Head turning with noise <input type="checkbox"/> Ear exam with pneumatic otoscope <input type="checkbox"/> Observational screening with noisemaker <input type="checkbox"/> ERA/ABR screen for infant in tertiary care > 5 days <input type="checkbox"/> Family history of hearing disorders PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> ear infection/ <input type="checkbox"/> head injury/ <input type="checkbox"/> congenital anomalies/ <input type="checkbox"/> meningitis/ <input type="checkbox"/> mumps/ <input type="checkbox"/> cerebral palsy <input type="checkbox"/> Language development	IX. VISION: (Check at least 1 item in this category) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> Regards hands <input type="checkbox"/> blinking <input type="checkbox"/> Likes faces <input type="checkbox"/> pupillary response <input type="checkbox"/> Smiles at mirror image - R <input type="checkbox"/> red reflex/fundus <input type="checkbox"/> Responds to bright colors <input type="checkbox"/> tracking <input type="checkbox"/> Reaches for objects <input type="checkbox"/> ocular movements <input type="checkbox"/> Cover test <input type="checkbox"/> focuses on objects and people, not lights <input type="checkbox"/> Family history of visual disorders <input type="checkbox"/> Attempts to pick up small objects, bits of food PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration
COMMENTS	COMMENTS

X. DENTAL <input type="checkbox"/> Baby bottle tooth decay syndrome <input type="checkbox"/> Normal tooth eruption times <input type="checkbox"/> Teething behavior <input type="checkbox"/> Assess teeth development and oral hygiene - Teeth cleaning <input type="checkbox"/> 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	COMMENTS

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____