



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF MEDICAL SERVICES
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
NEWBORN (2-3 DAYS) - 1 MONTH

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

<p>I. INTERVAL HISTORY/PARENT'S CONCERNS:</p> <p>History of pregnancy: Gestation _____ weeks Complications: _____</p> <p>History of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: _____</p> <p>Birth Wt: _____ Discharge Wt: _____ <input type="checkbox"/> Routine NB Care <input type="checkbox"/> NICU Complications/Concerns: _____</p> <p>History: _____</p> <p>Sleeping: _____ Child Care: _____ Family High Risk Factors: _____</p> <p>Parent's Concerns: _____</p> <p>Nutrition: <input type="checkbox"/> Breast _____ min/feeding _____ times per day <input type="checkbox"/> WIC Referral <input type="checkbox"/> Formula: _____, _____ oz/feeding _____ times per day</p> <p>Output: Urine: _____ Stools: _____ Diaper Rash: _____</p>	<p>COMMENTS</p>
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<p>II. UNCLOTHED PHYSICAL EXAM: <input type="checkbox"/> Check Growth Chart <input type="checkbox"/> Umbilical Cord</p>			
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	
Anus		<input type="checkbox"/> Patent	
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"/> No hipclick <input type="checkbox"/> Moves all extremities = <input type="checkbox"/> NL structure <input type="checkbox"/> NL tone <input type="checkbox"/> NL strength <input type="checkbox"/> Clavicles intact	
Neuro		<input type="checkbox"/> Moro + <input type="checkbox"/> Suck + <input type="checkbox"/> Root + <input type="checkbox"/> Grasp + <input type="checkbox"/> Plantar grasp + <input type="checkbox"/> Patellar DTR 2+/4=	
SIGNATURE			DATE

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"/> Sneezing, hiccups <input type="checkbox"/> Straining with stools <input type="checkbox"/> Parent-child interaction <input type="checkbox"/> Father's role <input type="checkbox"/> Family planning <input type="checkbox"/> Reading to child <input type="checkbox"/> Dressing/bathing <input type="checkbox"/> Sibling rivalry	<input type="checkbox"/> Safe handling of infant <input type="checkbox"/> Sleeping on back <input type="checkbox"/> Crib safety <input type="checkbox"/> Co-sleeping <input type="checkbox"/> Water heater temperature (<130 F) <input type="checkbox"/> Smoke detectors <input type="checkbox"/> Car seats <input type="checkbox"/> What is a fever? <input type="checkbox"/> Rectal Thermometer	<input type="checkbox"/> Saline nose drops <input type="checkbox"/> Parental smoking Feeding: <input type="checkbox"/> Feeding position <input type="checkbox"/> Iron/Vitamins <input type="checkbox"/> Breast-feeding support <input type="checkbox"/> Pacifier <input type="checkbox"/> Colic	COMMENTS
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IV: LAB/IMMUNIZATIONS: Lab: State newborn metabolic screen drawn Other 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 N/A for this age.

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

Minimal Skills <input type="checkbox"/> Regards face <input type="checkbox"/> Responds to voice/bell <input type="checkbox"/> Vocalizes-R	Emerging Skills <input type="checkbox"/> Spontaneous smile <input type="checkbox"/> Responsive smile <input type="checkbox"/> Regards own hand	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check at least 1 item in this category)

Minimal Skills <input type="checkbox"/> Equal movements <input type="checkbox"/> Follows to midline <input type="checkbox"/> Lifts head while prone-R	Emerging Skills <input type="checkbox"/> Follows past midline <input type="checkbox"/> Holds head up 45 degrees <input type="checkbox"/> Pushes chest up while prone	COMMENTS
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VIII. HEARING: (Check at least 1 item in this category)

Passed Newborn hearing screen
 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

COMMENTS

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

Parental perception of vision
Observation for
 blinking
 pupillary response
 red reflex
 tracking
 ocular movement
 Family history of visual disorders
 PMHx: NICU admission/ prolonged oxygen administration
 Note: Misalignment normal in first six months

COMMENTS

X. DENTAL: N/A at this age.

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____