



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

DATE		NAME		DATE OF BIRTH	
MO HEALTHNET NUMBER			MEDICAL RECORD NUMBER		
TEMP	RR	HEIGHT	%	BMI	ALLERGIES <input type="checkbox"/> NKDA
PULSE	HEAD CIRC	WEIGHT	%		MEDICATIONS <input type="checkbox"/> NONE
I. INTERVAL HISTORY/PARENT'S CONCERNS:					COMMENTS
Chronic Illnesses: _____ <input type="checkbox"/> ER/Hospital utilization since last visit					COMMENTS
<input type="checkbox"/> Triggers reviewed: _____					
<input type="checkbox"/> Medications changed/refilled: _____					
<input type="checkbox"/> Education <input type="checkbox"/> Consult/Referral					
Naps: _____					
Activity: _____					
Child Care: _____					
Injuries: _____					
Family High Risk Factors:* _____					
Nutrition: <input type="checkbox"/> Milk: _____, _____ oz/feeding _____ times per day <input type="checkbox"/> WIC Referral					
<input type="checkbox"/> Solid food (encourage all food groups: _____					
Output: Urine: _____ Stools: _____					
Diaper Rash: _____					
II. UNCLOTHED PHYSICAL EXAM: <input type="checkbox"/> Check Growth Chart					
SYSTEM	NL	ABN	NE	COMMENTS	
General					
Skin					
Head					
Eyes					
Ears					
Nose					
Oropharynx					
Neck					
Lungs					
Heart					
Pulses					
Abdomen					
Back					
GU					
Skeletal					
Neuro					
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 (I-V)	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	VISION SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>
DEVELOPMENTAL & MH SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>	DENTAL SCREEN	<input type="checkbox"/>	WITH REFERRAL	<input type="checkbox"/>

III. ANTICIPATORY GUIDANCE (Check all that apply)

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

Minimal Skills <input type="checkbox"/> Helps in house - R <input type="checkbox"/> Drinks from cup - R <input type="checkbox"/> Dada/Mama specific - R <input type="checkbox"/> Imitates activities - R <input type="checkbox"/> One word - R <input type="checkbox"/> Two words - R <input type="checkbox"/> Engages in reciprocal play <input type="checkbox"/> Appropriate emotional expression	Emerging Skills <input type="checkbox"/> Imitates words <input type="checkbox"/> 15-20 words <input type="checkbox"/> Follow directions <input type="checkbox"/> 2-word phrases <input type="checkbox"/> Spoon and cup <input type="checkbox"/> Name objects <input type="checkbox"/> Name body parts <input type="checkbox"/> Listen to story <input type="checkbox"/> Look at pictures	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills <input type="checkbox"/> Walks well <input type="checkbox"/> Scribbles <input type="checkbox"/> Bangs 2 cubes in hands - R <input type="checkbox"/> Puts block in cup <input type="checkbox"/> Walks backward - R <input type="checkbox"/> Stoops and recovers	Emerging Skills <input type="checkbox"/> Stacks 3-4 blocks <input type="checkbox"/> Runs <input type="checkbox"/> Imitates scribbles <input type="checkbox"/> Pulls toy <input type="checkbox"/> Walks quickly	COMMENTS
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VIII. HEARING: (Check all that apply) <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"/> Tympanometry <input type="checkbox"/> 3-4 words other than "Mama", "Dada" <input type="checkbox"/> Repeats sound	IX. VISION: (Check all that apply) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> Cover test <input type="checkbox"/> pupillary response <input type="checkbox"/> Enjoys short books, bright pictures <input type="checkbox"/> red reflex/fundus <input type="checkbox"/> tracking <input type="checkbox"/> ocular movements <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"/> Teeth brushing by parents <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 _____