



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
24-35 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"/> Sharing with others	<input type="checkbox"/> Outdoor hazards	<input type="checkbox"/> Nursery School	COMMENTS
<input type="checkbox"/> Peer play is parallel	<input type="checkbox"/> Water safety/pools	<input type="checkbox"/> Toilet training readiness	
<input type="checkbox"/> Tantrums*	<input type="checkbox"/> Balloon/plastic bag safety	<input type="checkbox"/> Masturbation	
<input type="checkbox"/> Autonomy/Choices	<input type="checkbox"/> Hot/Cold	Feeding:	
<input type="checkbox"/> Discipline/Time out*	<input type="checkbox"/> Water heater temperature (< 130 F)	<input type="checkbox"/> 3 meals with snacks	
<input type="checkbox"/> Matches, lighters	<input type="checkbox"/> Bathtub safety	<input type="checkbox"/> Variety of food	
<input type="checkbox"/> Television/Exercise	<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"/> Self feeding	
<input type="checkbox"/> Parental smoking	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Poor appetite*	

IV: LAB/IMMUNIZATIONS: Labs: Blood lead level (if not done previously at 24 months) Hct (if high risk) UA (if high risk)

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"/> Six words - R	Emerging Skills	COMMENTS
<input type="checkbox"/> Removes garments - R	<input type="checkbox"/> Plays with other children	<input type="checkbox"/> Imitates adults	<input type="checkbox"/> 2 step commands	
<input type="checkbox"/> Three words - R	<input type="checkbox"/> Appropriate emotional expression	<input type="checkbox"/> Asks for specific food	<input type="checkbox"/> Tells first and last name	
<input type="checkbox"/> Uses spoon, fork - R		<input type="checkbox"/> Uses pronouns	<input type="checkbox"/> ≥ 50 words	
<input type="checkbox"/> Points to 2 pictures		<input type="checkbox"/> 2-word phrases	<input type="checkbox"/> Unbuttons clothes	
		<input type="checkbox"/> Toilet training	<input type="checkbox"/> Attentive ≥ 2 minutes	

VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills	<input type="checkbox"/> Walks up steps - R	<input type="checkbox"/> Stacks 2-4 cubes	Emerging Skills	COMMENTS
<input type="checkbox"/> Runs	<input type="checkbox"/> Kicks ball forward	<input type="checkbox"/> Stacks 5-6 blocks	<input type="checkbox"/> Circular strokes	
<input type="checkbox"/> Dumps raisins from bottle - demonstrate		<input type="checkbox"/> Climbs up/down stairs	<input type="checkbox"/> Jumps well	
		<input type="checkbox"/> Imitates horizontal & vertical line		
		<input type="checkbox"/> Squats and recovers well		

VIII. HEARING: (Check all that apply)

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 all that apply)

Parental perception of vision

Observation for blinking Cover test

pupillary response Handles spoon well

red reflex/fundus Scribbles on paper

tracking ocular movements

Enjoys short books, bright pictures

Family history of visual disorders

Attempts to pick up small objects, bits of food

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