

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"/> 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. DEVELOPMENTAL AND MENTAL HEALTH: Parents As Teachers referral (Check all that apply)

Minimal Skills	<input type="checkbox"/> Names four pictures	<input type="checkbox"/> Attentive ≥ 5 min.	Emerging Skills	<input type="checkbox"/> Name, age, sex	<input type="checkbox"/> 3 adjectives	COMMENTS
<input type="checkbox"/> Puts on clothes -R	<input type="checkbox"/> Appropriate emotional expression	<input type="checkbox"/> Discuss activities	<input type="checkbox"/> Awareness of gender	<input type="checkbox"/> ≥ 4 colors	<input type="checkbox"/> Pronouns/plurals	
<input type="checkbox"/> Feed doll	<input type="checkbox"/> Seeks out interactions	<input type="checkbox"/> Past tense	<input type="checkbox"/> Brush teeth without help	<input type="checkbox"/> 3 word sentences		
<input type="checkbox"/> Brush teeth with help - R						
<input type="checkbox"/> Speech mostly understandable						

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

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

VIII. HEARING: (Check all that apply)	IX. VISION: (Check all that apply)
<input type="checkbox"/> Parental perception of hearing	<input type="checkbox"/> Parental perception of vision
<input type="checkbox"/> Ear exam with pneumatic otoscope	Observation for <input type="checkbox"/> blinking <input type="checkbox"/> ocular movements
<input type="checkbox"/> Observational screening with noisemaker	<input type="checkbox"/> pupillary response <input type="checkbox"/> tracking
<input type="checkbox"/> ERA/ABR screen for infant in tertiary care > 5 days	<input type="checkbox"/> Objective testing including Snellen E, distance acuity, and light reflex/cover test
<input type="checkbox"/> Family history of hearing disorders	<input type="checkbox"/> Exam of external eye, funduscopic exam
PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> ear infection/ <input type="checkbox"/> head injury/	<input type="checkbox"/> Family history of visual disorders
<input type="checkbox"/> congenital anomalies/ <input type="checkbox"/> meningitis/ <input type="checkbox"/> mumps/ <input type="checkbox"/> cerebral palsy	<input type="checkbox"/> Eye injuries, foreign substances
<input type="checkbox"/> Tympanometry	PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration
<input type="checkbox"/> Identifies familiar pictures	
<input type="checkbox"/> Names desired objects (candy, juice)	
COMMENTS	COMMENTS

X. DENTAL Dental referral for complete diagnostic work-up

<input type="checkbox"/> Teeth brushing by parents	<input type="checkbox"/> Normal tooth eruption times	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.
<input type="checkbox"/> Assess teeth development and oral hygiene - Teeth cleaning		
<input type="checkbox"/> Fluoride supplements if water fluoridation less than 0.7 ppm		
COMMENTS		

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____