

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 AND MENTAL HEALTH 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"/> Attention span* <input type="checkbox"/> Peers* <input type="checkbox"/> School attendance <input type="checkbox"/> School performance* <input type="checkbox"/> Reaction to strangers <input type="checkbox"/> Discipline/Time out* <input type="checkbox"/> Exercise/Physical activity <input type="checkbox"/> Reading to child <input type="checkbox"/> Gender awareness	<input type="checkbox"/> Traffic hazards <input type="checkbox"/> Swimming/diving <input type="checkbox"/> Gun safety <input type="checkbox"/> Fire safety <input type="checkbox"/> Matches, lighter safety <input type="checkbox"/> Bicycle helmet <input type="checkbox"/> Booster Seats/Airbags <input type="checkbox"/> Sun exposure <input type="checkbox"/> Smoke detector	<input type="checkbox"/> School readiness <input type="checkbox"/> Bed wetting* <input type="checkbox"/> Parental smoking Feeding: <input type="checkbox"/> 3 meals with snacks <input type="checkbox"/> Variety of food <input type="checkbox"/> Proper amounts <input type="checkbox"/> Obesity	COMMENTS
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IV: LAB/IMMUNIZATIONS: Labs: Hct (if high risk) UA (if high risk) Blood lead level (if not done previously at 24 months)

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 colors <input type="checkbox"/> Comprehends 4 prepositions <input type="checkbox"/> Speech all understandable <input type="checkbox"/> min. <input type="checkbox"/> Able to separate from parent	<input type="checkbox"/> Dresses without supervision - R <input type="checkbox"/> Attentive \geq 15 min.	Emerging Skills <input type="checkbox"/> Dresses without help <input type="checkbox"/> Recognizes alphabet <input type="checkbox"/> believe <input type="checkbox"/> Address and phone number	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills <input type="checkbox"/> Picks longer line <input type="checkbox"/> Draws person in 3 parts <input type="checkbox"/> Balances on each foot for 3 seconds	<input type="checkbox"/> Copies circle <input type="checkbox"/> Hops <input type="checkbox"/> Copies cross	Emerging Skills <input type="checkbox"/> Copies triangle/square <input type="checkbox"/> Jumps over low obstacles <input type="checkbox"/> Ties shoes	<input type="checkbox"/> Draw person - 6 parts <input type="checkbox"/> Prints some letters <input type="checkbox"/> Skips	COMMENTS
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VIII. HEARING: (Check all that apply)

<input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Ear exam with pneumatic otoscope <input type="checkbox"/> Observational screening with noisemaker <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"/> Identifies familiar pictures <input type="checkbox"/> Names desired objects (candy, juice) <input type="checkbox"/> Says all sounds correctly, except perhaps "s" and "th" <input type="checkbox"/> Pure tone audiometry (sweep screen)	IX. VISION: (Check all that apply) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> ocular movements <input type="checkbox"/> pupillary response <input type="checkbox"/> tracking <input type="checkbox"/> Objective testing including Snellen E, distance acuity, and light reflex/cover test, and color discrimination <input type="checkbox"/> Exam of external eye, funduscopic exam <input type="checkbox"/> Family history of visual disorders <input type="checkbox"/> Eye injuries, foreign substances PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration
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COMMENTS	COMMENTS
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X. DENTAL Referral for routine preventative dental care q 6 months

<input type="checkbox"/> Teeth brushing/flossing by parents <input type="checkbox"/> Normal tooth eruption times <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 preventative dental services and oral treatments for children begin at age 6-12 months and be repeated every 6 months or as medically indicated.
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ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE	DATE
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