



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"/> Traffic hazards	<input type="checkbox"/> School readiness	COMMENTS
<input type="checkbox"/> Peers*	<input type="checkbox"/> Swimming/diving	<input type="checkbox"/> Bed wetting*	
<input type="checkbox"/> School attendance/performance*	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Parental smoking	
<input type="checkbox"/> Reaction to strangers*	<input type="checkbox"/> Fire safety	Feeding:	
<input type="checkbox"/> Discipline*	<input type="checkbox"/> Bicycle helmet	<input type="checkbox"/> 3 meals with snacks	
<input type="checkbox"/> Exercise/Physical Activity	<input type="checkbox"/> Booster Seats/Seatbelts/Airbags	<input type="checkbox"/> Variety of food	
<input type="checkbox"/> Reading to child	<input type="checkbox"/> Sun exposure	<input type="checkbox"/> Proper amounts	
<input type="checkbox"/> Gender awareness	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Obesity	

**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 (at 6 years):  Negative screen  Positive screen - draw blood lead level.

**VI. DEVELOPMENTAL AND MENTAL HEALTH:** (Check all that apply)

<p>Minimal Skills</p> <input type="checkbox"/> Names four colors <input type="checkbox"/> Opposites -2 (6) <input type="checkbox"/> Count 5 blocks (6)	<p>Emerging Skills</p> <input type="checkbox"/> Reads simple words (6)	COMMENTS
<input type="checkbox"/> Dresses without supervision - R <input type="checkbox"/> Comprehends 4 prepositions		
<input type="checkbox"/> Plays boards and card games - R <input type="checkbox"/> Speech all understandable		
<input type="checkbox"/> Defines 7 words (6) <input type="checkbox"/> Prepares cereal (6) <input type="checkbox"/> Brush teeth - no help (6)		
<input type="checkbox"/> Appropriate emotional expression <input type="checkbox"/> Attentive ≥ 30 min.		

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

<p>Minimal Skills</p> <input type="checkbox"/> Picks longer line <input type="checkbox"/> Copies cross	<p>Emerging Skills</p> <input type="checkbox"/> Prints some letters	COMMENTS
<input type="checkbox"/> Draws person in 3 parts <input type="checkbox"/> Copies circle	<input type="checkbox"/> Ties shoes	
<input type="checkbox"/> Balances on each foot for 6 seconds (6) <input type="checkbox"/> Copies square (6)	<input type="checkbox"/> Skips	
<input type="checkbox"/> Heel to toe walk (6) <input type="checkbox"/> Hops <input type="checkbox"/> Draws person in 6 parts (6)	<input type="checkbox"/> Jumps over low obstacles	
<input type="checkbox"/> Handwriting		

<p><b>VIII. HEARING:</b> This screening should be performed annually.</p> <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"/> recurrent ear infections/ <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)	<p><b>IX. VISION:</b> This screening should be performed annually.</p> <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> pupillary response <input type="checkbox"/> tracking <input type="checkbox"/> ocular movement <input type="checkbox"/> Objective testing including Snellen E, distance acuity, light reflex/cover test, and color discrimination <input type="checkbox"/> Exam of external eye, funduscopy 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
--	---

COMMENTS

<p><b>X. DENTAL</b> <input type="checkbox"/> Referral for routine preventative dental care q 6 months</p> <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	<p>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.</p>
---	---

ASSESSMENT/EDUCATION/PLAN

\_\_\_\_\_

\_\_\_\_\_

ORDERS

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_