



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 MO HEALTHNET DIVISION  
**HEALTHY CHILDREN AND YOUTH SCREENING GUIDE**  
**NEWBORN (2-3 DAYS) - 1 MONTH**

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
<b>I. INTERVAL HISTORY/PARENT'S CONCERNS:</b> History of pregnancy: Gestation _____ weeks Complications: _____  History of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: _____  Birth Wt: _____ Discharge Wt: _____ <input type="checkbox"/> Routine NB Care <input type="checkbox"/> NICU Complications/Concerns: _____  History: _____  <input type="checkbox"/> Maternal Substance Use* Sleeping: _____ Child Care: _____ Family High Risk Factors:* _____  Parent's Concerns: _____ Nutrition: <input type="checkbox"/> Breast _____ min/feeding _____ times per day <input type="checkbox"/> <b>WIC Referral</b> <input type="checkbox"/> Formula: _____, _____ oz/feeding _____ times per day Output: Urine: _____ Stools: _____ Diaper Rash: _____					COMMENTS
<b>II. UNCLOTHED PHYSICAL EXAM:</b> <input type="checkbox"/> Check Growth Chart <input type="checkbox"/> Umbilical Cord _____					
SYSTEM	NL	ABN	NE	COMMENTS	
General					
Skin					
Head					
Eyes					
Ears					
Nose					
Oropharynx					
Neck					
Lungs					
Heart					
Pulses					
Abdomen					
Anus					
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 (1-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"/> Sneezing, hiccups <input type="checkbox"/> Straining with stools <input type="checkbox"/> Parent-child interaction* <input type="checkbox"/> Father's/Mother's role <input type="checkbox"/> Family planning <input type="checkbox"/> Reading to child <input type="checkbox"/> Dressing/bathing <input type="checkbox"/> Sibling rivalry	<input type="checkbox"/> Safe handling of infant <input type="checkbox"/> Sleeping on back <input type="checkbox"/> Crib safety <input type="checkbox"/> Co-sleeping <input type="checkbox"/> Water heater temperature (<130 F) <input type="checkbox"/> Smoke detectors <input type="checkbox"/> Car seats <input type="checkbox"/> What is a fever? <input type="checkbox"/> Rectal Thermometer	<input type="checkbox"/> Saline nose drops <input type="checkbox"/> Parental smoking <b>Feeding:</b> <input type="checkbox"/> Feeding position <input type="checkbox"/> Iron/Vitamins <input type="checkbox"/> Breast-feeding support <input type="checkbox"/> Pacifier <input type="checkbox"/> Colic	COMMENTS
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**IV: LAB/IMMUNIZATIONS:** Lab:  State newborn metabolic screen drawn  Other labs: \_\_\_\_\_

Immunizations given today: \_\_\_\_\_

UTD  Written information given  Consent signed (Follow the recommended immunization schedule approved by the ACIP, AAP, and AAFP)

**V. LEAD SCREEN** N/A for this age.

**VI. DEVELOPMENTAL AND MENTAL HEALTH:**  **Parents As Teachers referral** (Check all that apply)

<b>Minimal Skills</b> <input type="checkbox"/> Ability to be soothed* <input type="checkbox"/> Regards face <input type="checkbox"/> Responds to voice/bell <input type="checkbox"/> Cries/makes sound*	<b>Emerging Skills</b> <input type="checkbox"/> Spontaneous smile <input type="checkbox"/> Responsive smile <input type="checkbox"/> Regards own hand	COMMENTS
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**VII. FINE MOTOR/GROSS MOTOR:** (Check all that apply)

<b>Minimal Skills</b> <input type="checkbox"/> Equal movements <input type="checkbox"/> Follows to midline <input type="checkbox"/> Lifts head while prone-R	<b>Emerging Skills</b> <input type="checkbox"/> Follows past midline <input type="checkbox"/> Holds head up 45 degrees <input type="checkbox"/> Pushes chest up while prone	COMMENTS
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**VIII. HEARING:** (Check all that apply)

Passed Newborn hearing screen  
 Parental perception of hearing  
 Awakes to loud noise  
 Head turning with noise  
 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

COMMENTS

**IX. VISION:** (Check all that apply)

Parental perception of vision  
**Observation for**  
 blinking  
 pupillary response  
 red reflex  
 tracking  
 ocular movement  
 Family history of visual disorders  
 PMHx:  NICU admission/  prolonged oxygen administration  
 Note: Misalignment normal in first six months

COMMENTS

**X. DENTAL:** N/A at this age.

ASSESSMENT/EDUCATION/PLAN

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ORDERS

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