



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
12-14 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					
<input type="checkbox"/> Triggers reviewed: _____					
<input type="checkbox"/> Medications changed/refilled: _____					
<input type="checkbox"/> Education <input type="checkbox"/> Consult/Referral					
Sleeping: _____					
Activity: _____					
Child Care: _____					
Crossing Eyes: _____					
Family High Risk Factors:* _____					
Nutrition: <input type="checkbox"/> Breast _____ min/feeding _____ times per day <input type="checkbox"/> WIC Referral					
<input type="checkbox"/> Formula: _____, _____ oz/feeding _____ times per day					
<input type="checkbox"/> Solid food (encourage all food groups: _____)					
Output: Urine: _____ Stools: _____					
Diaper Rash: _____					

II. UNCLOTHED PHYSICAL EXAM: **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
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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"/> Getting into things <input type="checkbox"/> Discipline vs. Spoiling <input type="checkbox"/> Negatives <input type="checkbox"/> Expresses independence <input type="checkbox"/> Child-proofing cords, electrical sockets, plants, stairs <input type="checkbox"/> Reading to child <input type="checkbox"/> Parental smoking <input type="checkbox"/> Smoke detector	<input type="checkbox"/> Choking hazards - nuts, popcorn, hotdogs <input type="checkbox"/> Fences/gates <input type="checkbox"/> Firearms <input type="checkbox"/> Water heater temperature (<130 F) <input type="checkbox"/> Bathtub safety <input type="checkbox"/> Toddler car seats/Airbags <input type="checkbox"/> Poisons/medicines <input type="checkbox"/> Ipecac	Feeding: <input type="checkbox"/> Change to milk <input type="checkbox"/> Table food <input type="checkbox"/> Finger food <input type="checkbox"/> Weaning to cup <input type="checkbox"/> Vitamins <input type="checkbox"/> Proper serving sizes <input type="checkbox"/> Feeds self <input type="checkbox"/> Sweets	COMMENTS
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IV: LAB/IMMUNIZATIONS: LABS: HbG Hct UA (optional) Blood lead level (at 12 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 **Mandatory blood lead level testing is required at 12 months.**

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

Minimal Skills <input type="checkbox"/> Feeds self - R <input type="checkbox"/> Plays pat-a-cake - R <input type="checkbox"/> Exhibits range of emotions <input type="checkbox"/> Imitates speech sounds <input type="checkbox"/> Explores familiar environment	<input type="checkbox"/> Works for toy <input type="checkbox"/> Dada, Mama, non-specific - R <input type="checkbox"/> Combines syllables - R <input type="checkbox"/> Stranger anxiety	Emerging Skills <input type="checkbox"/> Comes when called <input type="checkbox"/> Begins using spoon/fork <input type="checkbox"/> Helps with dressing <input type="checkbox"/> 2-5 words <input type="checkbox"/> 1 step commands	<input type="checkbox"/> Imitates activities <input type="checkbox"/> Drinks from cup <input type="checkbox"/> Plays ball <input type="checkbox"/> Immature jargonning	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills <input type="checkbox"/> Takes two cubes <input type="checkbox"/> Bangs 2 cubes in hands - R <input type="checkbox"/> Pulls to stand	<input type="checkbox"/> Thumb-finger grasp <input type="checkbox"/> Stands 2 seconds <input type="checkbox"/> Gets to sitting - R	Emerging Skills <input type="checkbox"/> Spontaneous scribble <input type="checkbox"/> Stacks 2 blocks <input type="checkbox"/> Mature pincer grasp <input type="checkbox"/> Block in cup/dumps	<input type="checkbox"/> Stoops & recovers <input type="checkbox"/> Walks well <input type="checkbox"/> Walks backward <input type="checkbox"/> Runs stiffly	COMMENTS
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VIII. HEARING: (Check all that apply) <input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Awakes to loud noise <input type="checkbox"/> Head turning with noise <input type="checkbox"/> Ear exam with pneumatic otoscope <input type="checkbox"/> Observational screening with noisemaker <input type="checkbox"/> ERA/ABR screen for infant in tertiary care > 5 days <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	IX. VISION: (Check all that apply) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> pupillary response <input type="checkbox"/> red reflex/fundus <input type="checkbox"/> tracking <input type="checkbox"/> ocular movements <input type="checkbox"/> focuses on objects and people, not lights <input type="checkbox"/> Family history of visual disorders <input type="checkbox"/> Attempts to pick up small objects, bits of food PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration	<input type="checkbox"/> Regards hands <input type="checkbox"/> Likes faces <input type="checkbox"/> Smiles at mirror image - R <input type="checkbox"/> Responds to bright colors <input type="checkbox"/> Reaches for objects <input type="checkbox"/> Cover test	COMMENTS
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X. DENTAL <input type="checkbox"/> Baby bottle tooth decay syndrome <input type="checkbox"/> Normal tooth eruption times <input type="checkbox"/> Teething behavior <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 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
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ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____