



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
15-17 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					COMMENTS
<input type="checkbox"/> Triggers reviewed: _____					
<input type="checkbox"/> Medications changed/refilled: _____					
<input type="checkbox"/> Education <input type="checkbox"/> Consult/Referral					
Naps: _____					
Activity: _____					
Child Care: _____					
Crossing Eyes: _____					
Family High Risk Factors:* _____					
Nutrition: <input type="checkbox"/> Milk: _____, _____ oz/feeding _____ times per day <input type="checkbox"/> WIC Referral					
<input type="checkbox"/> Solid food (encourage all food groups: _____					
Output: Urine: _____ Stools: _____					
Diaper Rash: _____					
II. UNCLOTHED PHYSICAL EXAM: <input type="checkbox"/> 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	

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"/> Temper tantrums* <input type="checkbox"/> Rule setting <input type="checkbox"/> Simple games <input type="checkbox"/> Naps <input type="checkbox"/> Lower crib mattress <input type="checkbox"/> Matches, lighters <input type="checkbox"/> Knives <input type="checkbox"/> Reading to child <input type="checkbox"/> Parental smoking	<input type="checkbox"/> Choking hazards - nuts, popcorn, hotdog <input type="checkbox"/> Window guards <input type="checkbox"/> Hot/Cold <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"/> Smoke Detector	Speech development Feeding: <input type="checkbox"/> 3 meals with snacks <input type="checkbox"/> Soft drink warning <input type="checkbox"/> Self feeding <input type="checkbox"/> Using a cup <input type="checkbox"/> Variable appetite* <input type="checkbox"/> Proper serving sizes <input type="checkbox"/> Sweets	COMMENTS
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IV: LAB/IMMUNIZATIONS: Labs: Blood lead level (if not done previously) 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"/> Plays pat-a-cake - R <input type="checkbox"/> Waves bye-bye - R <input type="checkbox"/> Combines syllables - R <input type="checkbox"/> Jabbers - R <input type="checkbox"/> Dada/Mama specific - R	<input type="checkbox"/> Indicates wants - R <input type="checkbox"/> Exhibits a range of emotions <input type="checkbox"/> Engages in reciprocal play/imitates behavior	Emerging Skills <input type="checkbox"/> Simple commands <input type="checkbox"/> One body part <input type="checkbox"/> 3-6 words <input type="checkbox"/> Indicates wants without crying <input type="checkbox"/> Drinks from cup independently (no spout)	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills <input type="checkbox"/> Bangs 2 cubes in hands - R <input type="checkbox"/> Stoops and recovers <input type="checkbox"/> Walks well	<input type="checkbox"/> Thumb-finger grasp <input type="checkbox"/> Stands alone <input type="checkbox"/> Puts block in cup	Emerging Skills <input type="checkbox"/> Stacks 2 blocks <input type="checkbox"/> Walks backward <input type="checkbox"/> Runs	<input type="checkbox"/> Kicks ball <input type="checkbox"/> Climbs stairs <input type="checkbox"/> Uses spoon	COMMENTS
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VIII. HEARING: (Check all that apply)

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
 Tympanometry
 3-4 words other than "Mama", "Dada" Repeats sound

COMMENTS

IX. VISION: (Check all that apply)

Parental perception of vision
 Observation for
 blinking Cover test
 pupillary response Enjoys short books, bright pictures
 red reflex/fundus
 tracking
 ocular movements
 Family history of visual disorders
 Attempts to pick up small objects, bits of food
 PMHx: NICU admission/ prolonged oxygen administration

COMMENTS

X. DENTAL Teeth brushing by parents

Normal tooth eruption times Teething behavior
 Assess teeth development and oral hygiene - Teeth cleaning
 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

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____