

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"/> Thumb-sucking/Pacifier	<input type="checkbox"/> Rolling over and falls	<input type="checkbox"/> Acetaminophen dose	COMMENTS
<input type="checkbox"/> Crying*	<input type="checkbox"/> Sleeping on back	<input type="checkbox"/> Parental smoking	
<input type="checkbox"/> Parent-child interaction*	<input type="checkbox"/> Crib safety <input type="checkbox"/> Co-sleeping	<input type="checkbox"/> Colic	
<input type="checkbox"/> Father's/Mother's role	<input type="checkbox"/> Water heater temperature (<130 F)	Feeding:	
<input type="checkbox"/> Sibling rivalry	<input type="checkbox"/> Sun Exposure	<input type="checkbox"/> Iron/Vitamins	
<input type="checkbox"/> Reading to child	<input type="checkbox"/> Car seats	<input type="checkbox"/> Breast-feeding support	
<input type="checkbox"/> Stimulation-mobiles, safe toys	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Bottle-propping	
	<input type="checkbox"/> Ipecac	<input type="checkbox"/> Intro to new foods	

IV: LAB/IMMUNIZATIONS: 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)

Minimal Skills	<input type="checkbox"/> Eye contact for several seconds	Emerging Skills	COMMENTS
<input type="checkbox"/> Regards face	<input type="checkbox"/> Communicates fear, hunger, & discomfort	<input type="checkbox"/> Regards own hand	
<input type="checkbox"/> Responds to voice/bell		<input type="checkbox"/> Attends to voice	
<input type="checkbox"/> Vocalizes-R		<input type="checkbox"/> Laughs/squeals-R	
<input type="checkbox"/> Responsive smile		<input type="checkbox"/> Reciprocal vocalization - R	
<input type="checkbox"/> Ability to be soothed*		<input type="checkbox"/> Recognizes parents*	

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

Minimal Skills	Emerging Skills	COMMENTS
<input type="checkbox"/> Equal movements	<input type="checkbox"/> Follows past midline	
<input type="checkbox"/> Follows to midline	<input type="checkbox"/> Lifts head and chest off table	
<input type="checkbox"/> Lifts head 45 degrees while prone-R	<input type="checkbox"/> No longer clinches fists tightly	

VIII. HEARING: (Check all that apply)	IX. VISION: (Check all that apply)
<input type="checkbox"/> Passed Newborn hearing screen	<input type="checkbox"/> Parental perception of vision
<input type="checkbox"/> Parental perception of hearing	Observation for
<input type="checkbox"/> Awakes to loud noise	<input type="checkbox"/> blinking <input type="checkbox"/> Tear glands begin to function
<input type="checkbox"/> Head turning with noise	<input type="checkbox"/> pupillary response <input type="checkbox"/> Follows objects across midline
<input type="checkbox"/> Ear exam with pneumatic otoscope	<input type="checkbox"/> red reflex <input type="checkbox"/> Smiles responsively
<input type="checkbox"/> Observational screening with noisemaker	<input type="checkbox"/> tracking <input type="checkbox"/> ocular movement
<input type="checkbox"/> ERA/ABR screen for infant in tertiary care > 5 days	<input type="checkbox"/> Family history of visual disorders
<input type="checkbox"/> Family history of hearing disorders	PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration
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	Note: Misalignment normal in first six months
COMMENTS	COMMENTS

X. DENTAL: Baby bottle tooth decay syndrome Normal tooth eruption times

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____