

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"/> Peer relations* <input type="checkbox"/> Hobbies <input type="checkbox"/> Need for privacy <input type="checkbox"/> School performance* <input type="checkbox"/> Body image/dieting* <input type="checkbox"/> Discipline* <input type="checkbox"/> Exercise/Physical activity <input type="checkbox"/> Sex education/STD's <input type="checkbox"/> Television	<input type="checkbox"/> Firearms/Homicide* <input type="checkbox"/> Suicide* <input type="checkbox"/> Vehicular accidents <input type="checkbox"/> Sports injuries <input type="checkbox"/> Bicycle safety/helmet <input type="checkbox"/> Seatbelts/Airbags <input type="checkbox"/> Pool/Water safety <input type="checkbox"/> Chores <input type="checkbox"/> Contraception/Family planning	<input type="checkbox"/> Alcohol, drugs, smoking and driving* <input type="checkbox"/> Violent behavior* Feeding: <input type="checkbox"/> 3 balanced meals <input type="checkbox"/> Fat content <input type="checkbox"/> Iron <input type="checkbox"/> Calcium <input type="checkbox"/> Obesity	COMMENTS
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IV: LAB/IMMUNIZATIONS: Labs (if high risk): Hct UA Lipid profile Other: _____

If sexually active: PAP Rubella titer VDRL Chlamydia Gonorrhea HIV counseling HIV testing

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: (Check all that apply)

<input type="checkbox"/> Stable mood <input type="checkbox"/> Engages in age appropriate social activities <input type="checkbox"/> Follows rules/accepts discipline	<input type="checkbox"/> Stable behavior <input type="checkbox"/> School/vocational performance <input type="checkbox"/> Career planning	<input type="checkbox"/> Stable sleep/appetite <input type="checkbox"/> Career planning	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

<input type="checkbox"/> Handwriting <input type="checkbox"/> Sports	COMMENTS
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VIII. HEARING: This screening should be performed annually.

<input type="checkbox"/> Parental perception of hearing <input type="checkbox"/> Child's perception of hearing <input type="checkbox"/> Ear exam with pneumatic otoscope <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 upon indication <input type="checkbox"/> Pure tone audiometry (sweep screen) upon indication	IX. VISION: This screening should be performed annually. <input type="checkbox"/> Parental/child's perception of vision Observation for <input type="checkbox"/> blinking <input type="checkbox"/> tracking <input type="checkbox"/> pupillary response <input type="checkbox"/> ocular movement <input type="checkbox"/> Objective testing including Snellen E, acuity (near and far), and color discrimination <input type="checkbox"/> Exam of external eye, fundusoscopic 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
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COMMENTS	COMMENTS
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X. DENTAL Dental referral for complete diagnostic workup and orthodontic evaluation, if not done

<input type="checkbox"/> Teeth brushing/flossing <input type="checkbox"/> Referral for routine preventative dental care q 6 months <input type="checkbox"/> Assess teeth development and oral hygiene - Teeth cleaning	<input type="checkbox"/> Fluoride supplements if water fluoridation less than 0.7 ppm (until all permanent teeth have erupted.) COMMENTS
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ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE	DATE
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