



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 MO HEALTHNET DIVISION  
**HEALTHY CHILDREN AND YOUTH SCREENING GUIDE**  
**4-5 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

<b>I. INTERVAL HISTORY/PARENT'S CONCERNS:</b>	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"/> <b>WIC Referral</b> <input type="checkbox"/> Formula: _____, _____ oz/feeding _____ times per day <input type="checkbox"/> Solid food: _____	
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"/> Thumb-sucking/Pacifier <input type="checkbox"/> Teething <input type="checkbox"/> Stimulation - safe toys <input type="checkbox"/> Parent-child interaction* <input type="checkbox"/> Father's/Mother's role <input type="checkbox"/> Siblings <input type="checkbox"/> Travel <input type="checkbox"/> Reading to child	<input type="checkbox"/> Foreign bodies <input type="checkbox"/> Rolling over and falls <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"/> Sun/Cold Exposure <input type="checkbox"/> Car seats/Airbags <input type="checkbox"/> Smoke detector <input type="checkbox"/> Poisons	<input type="checkbox"/> Acetaminophen dose <input type="checkbox"/> Ipecac <input type="checkbox"/> Respiratory infections <input type="checkbox"/> Parental smoking Feeding: <input type="checkbox"/> Iron/Vitamins <input type="checkbox"/> Breast-feeding support <input type="checkbox"/> Bottle-propping <input type="checkbox"/> Intro to new foods, cereals	COMMENTS
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**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)

<b>Minimal Skills</b> <input type="checkbox"/> Regards face <input type="checkbox"/> Responsive smile <input type="checkbox"/> Laughs/Squeals - R <input type="checkbox"/> Uses voice to show emotions	<input type="checkbox"/> Responds to touch & being held <input type="checkbox"/> Vocalizes - R <input type="checkbox"/> "OOO/AAH" - R	<b>Emerging Skills</b> <input type="checkbox"/> Babbles/Coos <input type="checkbox"/> Turns to voice/sound <input type="checkbox"/> Recognizes parent	<input type="checkbox"/> Imitates speech sounds <input type="checkbox"/> Single syllables <input type="checkbox"/> Comforts self	COMMENTS
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**VII. FINE MOTOR/GROSS MOTOR:** (Check all that apply)

<b>Minimal Skills</b> <input type="checkbox"/> Follows to midline <input type="checkbox"/> Follows past midline <input type="checkbox"/> Grasps rattle/toy <input type="checkbox"/> Head up 90 degrees <input type="checkbox"/> Pulls to sitting position, head steady	<b>Emerging Skills</b> <input type="checkbox"/> Works for toy <input type="checkbox"/> Plays with hands <input type="checkbox"/> Hands to midline <input type="checkbox"/> Hands open <input type="checkbox"/> Reach and grasp	<input type="checkbox"/> Sits with support <input type="checkbox"/> Rolls front to back <input type="checkbox"/> Rolls back to front <input type="checkbox"/> Transfers objects <input type="checkbox"/> Pushes up on hands <input type="checkbox"/> Pulls to sit no head lag	COMMENTS
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<b>VIII. HEARING:</b> (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"/> Language development	<b>IX. VISION:</b> (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 <input type="checkbox"/> tracking <input type="checkbox"/> ocular movement <input type="checkbox"/> Tear glands begin to function <input type="checkbox"/> Follows objects across midline <input type="checkbox"/> Smiles responsively <input type="checkbox"/> Responds to bright colors <input type="checkbox"/> Reaches for objects <input type="checkbox"/> Cover test <input type="checkbox"/> Likes faces <input type="checkbox"/> Family history of visual disorders PMHx: <input type="checkbox"/> NICU admission/ <input type="checkbox"/> prolonged oxygen administration Note: Misalignment normal in first six months	COMMENTS
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**X. DENTAL:**  Baby bottle tooth decay syndrome  Normal tooth eruption times

ASSESSMENT/EDUCATION/PLAN  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ORDERS

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