



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
6-8 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:

Chronic Illnesses: _____ ER/Hospital utilization since last visit

Triggers reviewed: _____

Medications changed/refilled: _____

Education Consult/Referral

Sleeping: _____

Activity: _____

Child Care: _____

Crossing Eyes: _____

Family High Risk Factors:* _____

Nutrition: Breast _____ min/feeding _____ times per day **WIC Referral**

Formula: _____, _____ oz/feeding _____ times per day

Solid food: _____

Output: Urine: _____ Stools: _____

Diaper Rash: _____

COMMENTS

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 |
|-----------|------|

| | | | | | | | |
|---------------------------|--------------------------|---------------|--------------------------|----------------|--------------------------|---------------|--------------------------|
| 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"/> Night crying <input type="checkbox"/> Stimulation - safe toys <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Parent-child interaction* <input type="checkbox"/> Child-proofing cords, electrical sockets, plants, stairs <input type="checkbox"/> Reading to child <input type="checkbox"/> Respiratory infections <input type="checkbox"/> Parental smoking | <input type="checkbox"/> Foreign bodies <input type="checkbox"/> Safe high chair <input type="checkbox"/> Crib safety <input type="checkbox"/> Co-sleeping <input type="checkbox"/> Water heater temperature (<130 F) <input type="checkbox"/> Bathtub safety <input type="checkbox"/> Playpen safety <input type="checkbox"/> Car seats/Airbags <input type="checkbox"/> Poisons <input type="checkbox"/> Smoke detector | <input type="checkbox"/> Acetaminophen dose <input type="checkbox"/> Ipecac 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, vegetables, fruits <input type="checkbox"/> Eating with hands | COMMENTS |
|--|---|---|----------|

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 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"/> Attachment to caretaker <input type="checkbox"/> Engages in social play <input type="checkbox"/> Works for toy <input type="checkbox"/> Recognizes parent | <input type="checkbox"/> Reciprocal emotions <input type="checkbox"/> Laughs - R <input type="checkbox"/> Squeals - R | Emerging Skills <input type="checkbox"/> Vocalizes consonants <input type="checkbox"/> Stranger anxiety <input type="checkbox"/> Imitates razzing <input type="checkbox"/> Reciprocal babbles <input type="checkbox"/> Comforts self | COMMENTS |
|--|---|---|----------|

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

| | | | |
|--|---|--|----------|
| Minimal Skills <input type="checkbox"/> Rolls over - R <input type="checkbox"/> Reaches <input type="checkbox"/> Follows object 180 degrees <input type="checkbox"/> Regards raisin <input type="checkbox"/> Lifts chest up with arm support | Emerging Skills <input type="checkbox"/> Unilateral reach <input type="checkbox"/> Rolls both ways <input type="checkbox"/> Bears weight <input type="checkbox"/> Sits without support <input type="checkbox"/> No head lag | <input type="checkbox"/> Rakes with fingers <input type="checkbox"/> Begins self feeding <input type="checkbox"/> Transfers objects <input type="checkbox"/> Grasp and mouthing | COMMENTS |
|--|---|--|----------|

| | |
|---|--|
| 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"/> Language development | IX. VISION: (Check all that apply) <input type="checkbox"/> Parental perception of vision Observation for <input type="checkbox"/> Regards hands <input type="checkbox"/> blinking <input type="checkbox"/> Follows objects across midline <input type="checkbox"/> pupillary response <input type="checkbox"/> Smiles at mirror image - R <input type="checkbox"/> red reflex/fundus <input type="checkbox"/> Responds to bright colors <input type="checkbox"/> tracking <input type="checkbox"/> Reaches for objects <input type="checkbox"/> Cover test <input type="checkbox"/> focuses on objects and people, not lights <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 | COMMENTS |

| | |
|---|--|
| 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 | COMMENTS |

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE _____ DATE _____