



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
9-11 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							
<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"/> WIC Referral							
<input type="checkbox"/> Formula: _____, _____ oz/feeding _____ times per day							
<input type="checkbox"/> Solid food: _____							
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"/> Loss of appetite* <input type="checkbox"/> Discipline <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Strangers <input type="checkbox"/> Child-proofing cords, electrical sockets, plants, stairs <input type="checkbox"/> Reading to child <input type="checkbox"/> Stimulation <input type="checkbox"/> Parental smoking	<input type="checkbox"/> Choking hazards - nuts, popcorn, hotdogs <input type="checkbox"/> Safe walkers <input type="checkbox"/> Stair guards <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"/> 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"/> Weaning to cup <input type="checkbox"/> Intro to new foods, cereals, vegetables, fruits, meats <input type="checkbox"/> Mashed table food	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 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"/> Single syllables - R <input type="checkbox"/> Turns toward voice <input type="checkbox"/> Feeds self - R	<input type="checkbox"/> Regards own hand - R <input type="checkbox"/> Imitates speech sounds <input type="checkbox"/> Expresses/responds to emotions	Emerging Skills <input type="checkbox"/> Responds to name <input type="checkbox"/> Interactive games <input type="checkbox"/> Stranger anxiety/leave <input type="checkbox"/> Mama/dada, specific	<input type="checkbox"/> Waves bye-bye <input type="checkbox"/> Indicates wants <input type="checkbox"/> Drinks from cup <input type="checkbox"/> 1-2 additional words	COMMENTS
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VII. FINE MOTOR/GROSS MOTOR: (Check all that apply)

Minimal Skills <input type="checkbox"/> Looks for yarn/object <input type="checkbox"/> Rakes raisin <input type="checkbox"/> Passes cube	<input type="checkbox"/> Stands, holding on <input type="checkbox"/> Pulls to sit, no head lag <input type="checkbox"/> Sits without support	Emerging Skills <input type="checkbox"/> Inferior pincer grasp <input type="checkbox"/> Bangs two blocks <input type="checkbox"/> Holds bottle <input type="checkbox"/> Gets to sitting position	<input type="checkbox"/> Stands 2 seconds <input type="checkbox"/> Probes with fingers <input type="checkbox"/> Puts block in cup <input type="checkbox"/> Crawls <input type="checkbox"/> Pulls to stand/cruises	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
 Language development

COMMENTS

IX. VISION: (Check all that apply)

Parental perception of vision
 Observation for
 blinking
 pupillary response
 red reflex/fundus
 tracking
 ocular movements
 focuses on objects and people, not lights
 Family history of visual disorders
 Attempts to pick up small objects, bits of food
 PMHx: NICU admission/ prolonged oxygen administration

COMMENTS

X. DENTAL Baby bottle tooth decay syndrome

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 _____