MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

HEALTHY CHILDREN AND YOUTH SCREENING GUIDE
NEWBORN (2-3 DAYS) - 1 MONTH

DATE	NAME		DATE OF BIRTH		
MO HEALTHNET NUMBER			MEDICAL RECORD NUMBER		
TEMP	RR	HEIGHT	%	BMI	ALLERGIES ☐ NKDA
PULSE	HEAD CIRC %	WEIGHT	%		MEDICATIONS ☐ NONE

I. INTERVAL HISTORY/PARENT'S CONCERNS:

History of pregnancy: Gestation _____ weeks
Complications: _____

History of delivery: ☐ Vaginal ☐ C-section
Complications: _____

Birth Wt: _____ Discharge Wt: _____ ☐ Routine NB Care ☐ NICU
Complications/Concerns: _____

History: _____

☐ Maternal Substance Use*

Sleeping: _____
Child Care: _____
Family High Risk Factors:* _____
Parent's Concerns: _____
Nutrition: ☐ Breast _____ min/feeding _____ times per day ☐ **WIC Referral**
☐ Formula: _____ , _____ oz/feeding _____ times per day
Output: Urine: _____ Stools: _____
Diaper Rash: _____

COMMENTS

II. UNCLOTHED PHYSICAL EXAM: ☐ **Check Growth Chart** ☐ Umbilical Cord _____

SYSTEM	NL	ABN	NE	COMMENTS
General				
Skin				
Head				
Eyes				
Ears				
Nose				
Oropharynx				
Neck				
Lungs				
Heart				
Pulses				
Abdomen				
Anus				
Back				
GU				
Skeletal				
Neuro				

SIGNATURE	DATE

FULL SCREEN (I-X) ☐	WITH REFERRAL ☐	HEARING SCREEN ☐	WITH REFERRAL ☐
PARTIAL SCREEN (1-V) ☐	WITH REFERRAL ☐	VISION SCREEN ☐	WITH REFERRAL ☐
DEVELOPMENTAL & MH SCREEN ☐	WITH REFERRAL ☐	DENTAL SCREEN ☐	WITH REFERRAL ☐

III. ANTICIPATORY GUIDANCE (Check all that apply)

☐ Sneezing, hiccups ☐ Straining with stools ☐ Parent-child interaction* ☐ Father's/Mother's role ☐ Family planning ☐ Reading to child ☐ Dressing/bathing ☐ Sibling rivalry	☐ Safe handling of infant ☐ Sleeping on back ☐ Crib safety ☐ Co-sleeping ☐ Water heater temperature (<130 F) ☐ Smoke detectors ☐ Car seats ☐ What is a fever? ☐ Rectal Thermometer	☐ Saline nose drops ☐ Parental smoking Feeding: ☐ Feeding position ☐ Iron/Vitamins ☐ Breast-feeding support ☐ Pacifier ☐ Colic	COMMENTS

IV: LAB/IMMUNIZATIONS: Lab: ☐ State newborn metabolic screen drawn ☐ Other 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 ☐ Ability to be soothed* ☐ Regards face ☐ Responds to voice/bell ☐ Cries/makes sound*	Emerging Skills ☐ Spontaneous smile ☐ Responsive smile ☐ Regards own hand	COMMENTS

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

Minimal Skills ☐ Equal movements ☐ Follows to midline ☐ Lifts head while prone-R	Emerging Skills ☐ Follows past midline ☐ Holds head up 45 degrees ☐ Pushes chest up while prone	COMMENTS

VIII. HEARING: (Check all that apply) ☐ Passed Newborn hearing screen ☐ 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	**IX. VISION:** (Check all that apply) ☐ Parental perception of vision Observation for ☐ blinking ☐ pupillary response ☐ red reflex ☐ tracking ☐ ocular movement ☐ Family history of visual disorders PMHx: ☐ NICU admission/ ☐ prolonged oxygen administration Note: Misalignment normal in first six months
COMMENTS	COMMENTS

X. DENTAL: N/A at this age.

ASSESSMENT/EDUCATION/PLAN

ORDERS

SIGNATURE	DATE