

Florida Medicaid

Child Health Check-Up Coverage and Limitations Handbook

Agency for Health Care Administration



UPDATE LOG

CHILD HEALTH CHECK-UP COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages. It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.
Update No. is the month and year that the update was issued.
Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in the Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
New Handbook	January 1, 1989
89-1-Update	August 1, 1989
91-1-Update	September 1, 1991
92-1-Update	January 1, 1992
92-2-Update	May 1, 1992
93-1-Update	March 1, 1993
95-1-Update	January 1995
New Handbook	December 1996
97-1-Update	July 1997
New Handbook	May 2000
Oct2003	October 2003

CHILD HEALTH CHECK-UP COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used to prepare the Medicaid Reimbursement and Coverage and Limitations Handbooks and tells the reader how to use the handbooks.

Background

The Coverage and Limitations Handbook explains covered services, their limits and who is eligible to receive them. It is to be used with the Reimbursement Handbook, which describes how to complete and file claims for reimbursement by Medicaid, and the General Handbook, which describes the Florida Medicaid Program.

Legal Authority

The Medicaid program is authorized by Title XIX of the Social Security Act and Title 42, Code of Federal Regulations. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

Federal Regulations, Florida Statutes, and the Florida Administrative Code, which deal with the purpose, implementation, and administration of each Medicaid program, are cited for reference in each service-specific Coverage and Limitations Handbook.

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Handbook Use and Format

Purpose The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

“Provider” The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

“Recipient” The term “recipient” is used to describe an individual who is eligible for Medicaid.

Coverage and Limitations Handbook Each service handbook is named for the service it describes and is referred to as a "Coverage and Limitations Handbook." A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

Reimbursement Handbook Each reimbursement handbook is named for the claim form that it describes. A provider that bills on more than one type of claim form will have more than one reimbursement handbook.

General Handbook General information regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy and important resources for providers are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

Chapter Numbering System The first page of each chapter designates the chapter number. The chapter number will appear as the first number of the page number at the bottom of each page in the handbook.

Page Numbering Pages are numbered consecutively by chapter. Page numbers follow the chapter number found at the bottom of each page.

Handbook Use and Format, continued

White Space	The "white space" throughout a handbook is characteristic of the handbook format style. It enhances readability and allows space for writing notes during training and for on-the-job reference.
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Characteristics of the Handbook

Format	The format used in this handbook represents a concise and consistent way of displaying complex, technical material.
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Information Block	One of the major features of the format is the information block, which replaces the traditional paragraph. Blocks are separated by horizontal lines. The block consists of one or more paragraphs or diagrams about a portion of a subject. Each block is identified or named with a label.
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Label	Labels or names are located in the left margin of each information block. They describe the content or function of the block. Labels provide key subject matter identification which facilitates scanning and locating information quickly within a chapter or section within a chapter.
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Note	<u>Note</u> : is used most frequently to refer the user to material located elsewhere in a handbook that is pertinent to the subject being addressed within the information block. <u>Note</u> : also refers the user to other documents or policies contained in other handbooks.
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Topic Roster	Each chapter contains a topic roster which lists the major subject areas covered in the chapter and gives the page number where the subject can be found. This topic roster serves as a table of contents for major sections within each chapter.
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Handbook Updates

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Brief changes will be sent as pen and ink updates. The pen and ink updates will be incorporated on replacement pages the next time replacement pages are produced.
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Handbook Updates, continued

Numbering Update Pages

Updated replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the proceeding replacement page with an alphabetic character in ascending order.

Update Log

A page designated as the log will accompany handbook updates. This log serves as a reference for the provider to be sure that each update has been received.

An "Update No." will be indicated in the first column on the update log. The second column is titled "Effective Date" and indicates the date that the update was effective.

Effective Date of New Material

The month and year that the new material is effective will appear on the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date for the information block will be included in the label.

Identifying New Information

New material will be indicated by solid vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a solid vertical line to the left and right of the label only.

New Label/New Information Block

A new label and a new information block will be identified by a solid vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a solid vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a solid vertical line to the left and right of the paragraph.

CHAPTER 1

CHILD HEALTH CHECK-UP

PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Florida Medicaid Child Health Check-Up Program, provider eligibility, and the requirements for enrollment. “Child Health Check-Up” is Florida’s name for the federal program known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Legal Authority

The Child Health Check-Up Program is governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 441, Subpart B. The program was implemented through Chapter 409.905, Florida Statutes, and Chapter 59G, Florida Administrative Code.

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Purpose and Description

Purpose

The purpose of the Child Health Check-Up Program is to provide the following services to children from birth through age 20:

- Comprehensive, preventive, well child care on a regularly scheduled basis;
- Identification and correction of medical conditions before the conditions become serious and disabling; and
- An entry into the health care system and access to a medical home.

Purpose and Description, continued

Child Health Check-Up

A Child Health Check-Up is a comprehensive, preventive health screening service. Child Health Check-Ups are performed according to a periodicity schedule that ensures that children have a health screening on a routine basis. In addition, a child may receive a Child Health Check-Up whenever it is medically necessary or requested by the child or the child's parent or caregiver. If a child is diagnosed as having a medical problem, the child is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

Note: See Chapter 2, page 2-4, of this handbook for the definition of medically necessary.

Definition of Child

For the purpose of this program, the term "child" refers to any child who is eligible for medical care as defined by Florida Medicaid policy and is enrolled as a recipient to receive those services.

Medicaid Child Health Check-Up Coordinators

Medicaid Child Health Check-Up coordinators are located in the area Medicaid offices. The Child Health Check-Up coordinators provide outreach services to recipients and training to providers to encourage participation in the Child Health Check-Up Program.

They assist recipients who are not in managed health care plans with scheduling appointments, arranging transportation, and following up on further diagnoses and treatment services. They assist managed care providers with scheduling appointments and arranging transportation for their recipients for services not covered by managed care providers.

Note: See the Florida Medicaid Provider General Handbook, for the addresses and phone numbers of the area Medicaid offices.

CMS-1500 Claim Form for Paper Claim Submission

Beginning with the Health Insurance Portability and Accountability Act (HIPAA) implementation, a Child Health Check-Up must be billed on the CMS-1500 claim form for paper claim submission. Instructions for completing the CMS-1500 claim form for a Child Health Check-Up, are in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Effective with HIPAA Implementation

Note: For electronic claim submission, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Provider Qualifications

Enrollment Requirements

Child Health Check-Up is a category of service that certain Medicaid providers may render. To provide Child Health Check-Ups, a provider must be enrolled in Medicaid as a provider with a Category of Service (code 55) for Child Health Check-Ups.

Who Can Provide Child Health Check-Up Services

The following provider types may enroll as Child Health Check-Up providers:

Providers:

- Advanced registered nurse practitioners (ARNPs)
- Health Maintenance Organizations (HMOs)
- Licensed Midwives*
- Medical physicians
- Osteopathic physicians
- Physician assistants

Facilities:

- Birthing Centers*
- Children's Medical Services clinics
- County health departments
- Federally qualified health centers
- Hospitals (outpatient only)
- Rural health clinics
- School Districts

*Birthing Centers and Licensed Midwives are limited to the newborn evaluation only.

Provider Enrollment

General Enrollment Requirements

Child Health Check-Up providers must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook.

Child Health Check-Up Category of Service

To be reimbursed for Child Health Check-Ups, the provider must be one of the provider types listed in the Provider Qualifications section (stated earlier in this chapter) and be enrolled in Medicaid as a provider with a Category of Service (Code 55) for Child Health Check-Ups. The provider must request that the Medicaid fiscal agent add the Child Health Check-Up category of service to their provider file.

Site Visits

In accordance with §409.907(7), Florida Statutes, providers may be subject to random onsite inspections before enrollment.

Provider Responsibilities

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective with HIPAA Implementation. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 800-829-0218.

Provider Responsibilities, continued

Provider Responsibilities

A Child Health Check-Up provider is responsible for:

- Providing or coordinating all the required components of the Child Health Check-Up and ensuring that the health screening is conducted in full accordance with program regulations;
- Ensuring that initial and periodic health screenings are available to eligible individuals;
- Retaining the required documentation of the health screening in the recipient's medical record;
- Making appropriate referrals and follow-up for further diagnosis and treatment of those problems that the provider cannot treat;
- Offering the recipient freedom of choice on direct referrals to providers for further diagnosis and treatment as described below; and
- Reporting any evidence of neglect or suspected child abuse indicated by the developmental history or health screening to the Abuse Registry at 800-342-9152. Providers must report all supporting evidence.

Note: See the Florida Medicaid Provider General Handbook, for additional provider responsibilities and record keeping requirements.

Referrals

If the recipient is enrolled in MediPass, the MediPass primary care provider must authorize follow-up services.

If the recipient is in an HMO, the referral will be to providers in the HMO network. Referrals to providers outside of the HMO network may occur when a medically indicated specialist is not available within the HMO network.

CHAPTER 2

CHILD HEALTH CHECK-UP COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the Child Health Check-Up Program, the periodicity schedule, and the required Child Health Check-Up components.

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Service Requirements

Introduction

The Child Health Check-Up Program covers a comprehensive, preventive health screening for Medicaid eligible children from birth through age 20 and children from 1 year of age through age 4 who are enrolled in the MediKids program.

Service Requirements, continued

Required Components

To be reimbursed by Medicaid, the provider must assess and document in the child's medical record all the required components of a Child Health Check-Up. The required components are as follows:

- Comprehensive Health and Developmental History including assessment of past medical history, developmental history and behavioral health status;
- Nutritional assessment;
- Developmental assessment;
- Comprehensive unclothed physical examination;
- Dental screening including dental referral, when required;
- Vision screening including objective testing, when required;
- Hearing screening including objective testing, when required;
- Laboratory tests including blood lead testing, when required;
- Appropriate immunizations;
- Health education, anticipatory guidance;
- Diagnosis and treatment; and
- Referral and follow-up, as appropriate.

Note: See the specific component topics in this chapter for detailed information on the components.

Note: See Appendix G for the Child Health Check-Up Audit Tool. The Child Health Check-Up Audit Tool is to be used for all Provider Types by Medicaid reviewers and auditors in assessing policy compliance.

Previously Provided Component

If a component was performed within approximately 90 days before the Child Health Check-Up and the results were documented, the provider does not need to repeat the component. An exception should be made if the child's environment or medical condition indicates that the component should be repeated.

Or if, based on medical discretion, a component has not been performed within approximately 90 days, but within a reasonable time based on the child's age and with documentation of medically appropriate rationale, i.e., 2 year old participates in the Early Intervention program, the provider does not need to repeat the component.

Service Requirements, continued

**Child Health
Check-Up Forms**

Providers may use the Child Health Check-Up Tracking Forms to address and document the required components. The forms were developed by a workgroup composed of members of the Florida Pediatric Society, the Florida Chapter of the American Academy of Pediatrics; the Florida Academy of Family Physicians; the Florida Medical Association; and the Florida Osteopathic Medical Association. These forms were designed to capture all required components of the Child Health Check-Up.

Medicaid's Child Health Check-Up Program also has an optional Initial Comprehensive Health and Developmental History Form that may be used.

Use of these forms is optional; however, if a provider does not use the forms, he or she must still assess and document all the required components.

Note: See Appendix B for a copy of the optional Child Health Check-Up Tracking Forms and Appendix C for a copy of the optional Child Health Check-Up Initial Comprehensive Health and Developmental History Form. The provider may make photocopies of the form(s) to use for Child Health Check-Ups.

If the Child is Sick

A Child Health Check-Up should not be performed on an obviously sick child where findings may be distorted. Provider discretion in evaluating the degree of illness should determine if a Child Health Check-Up should be performed.

Providers may only bill for one visit, a sick visit or a Child Health Check-Up. If the child is sick, the provider should treat or refer the child for the illness and reschedule the Child Health Check-Up.

**Diagnosis,
Treatment, Referral
and Follow-Up**

Under federal law, Florida provides medically necessary treatment for all medical conditions that are diagnosed from a Child Health Check-Up.

Once the child has had a Child Health Check-Up, any further diagnoses and treatments, referrals and follow-up are provided through the applicable Medicaid program, such as physician services.

Service Requirements, continued

Medically Necessary

Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Child Health Check-Up Periodicity Schedule

Introduction

To receive Medicaid reimbursement for Child Health Check-Ups, providers must follow the Child Health Check-Up periodicity schedule. The schedule is based on the American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care" and Florida Medicaid's recommendation to include the 7 and 9 year old recipients.

Child Health Check-Up Periodicity Schedule, continued

Child Health Check-Up Periodicity Schedule

The Child Health Check-Up schedule is:

- Birth or neonatal examination
- 2-4 days for newborns discharged in less than 48 hours after delivery
- By 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- Once per year for 2 through 20 year olds*

The child may enter the periodicity schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5.

* Florida Medicaid recommends check-ups at 7 and 9 years of age for those children at risk.

Note: See Appendix D, "Recommendations for Preventive Pediatric Health Care."

Young Adult Recipients Who Are 20 Years of Age

Young adult recipients are eligible to receive a Child Health Check-Up through age 20. However, in order to receive a Child Health Check-Up and necessary treatment, young adult recipients should be screened at least 180 days before they turn 21 years old.

Intermediate Care Facilities for the Developmentally Disabled (ICF-DD)

Medicaid children who reside in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) are not eligible for Child Health Check-Up services. Federal regulations require ICF-DDs to provide routine medical and preventive care for their residents.

Interperiodic Child Health Check-Ups

Medicaid reimburses interperiodic Child Health Check-Ups that are medically necessary or requested by the child or the child's parent or caregiver. The determination of whether an interperiodic Child Health Check-Up is medically necessary may be made by the provider or a health, developmental, or educational professional that has contact with the child.

Note: Children who are removed from their homes by DCF due to allegations of abuse, abandonment or neglect are eligible for a Child Health Check-Up based on medical necessity.

Comprehensive Health and Developmental History

Description

The comprehensive health and developmental history consists of documenting the child's physical, behavioral and developmental health.

Required

The provider must assess the child's health and developmental history, which includes past medical history, developmental history, and behavioral health status (including mental health development)*, and document the findings in the child's medical record.

* Note: See the Bright Futures web site at www.brightfutures.org for Bright Futures in Practice: Mental Health and AAP web site at www.aap.org for information on mental health and substance abuse.

Behavioral Health and Developmental Screening Form

Providers, based on medical discretion, may use the Behavioral Health and Developmental Screening Form to determine the child's behavioral and developmental health. If the child has a positive response to any of the questions on the Behavioral Health and Developmental Screening Form, the child should be referred for further evaluation.

Note: See Appendix E for the updated Behavioral Health and Developmental Screening Form. Providers may photocopy this form for their use.

Required Frequency

The provider must assess and document a comprehensive health and developmental history of the child at each Child Health Check-Up. If the child's status remains the same, the provider must document this.

Additional Information or Records

The provider should request medically relevant additional information or records from health care professionals or organizations that previously provided health care to the recipient.

HIV Testing

If the HIV status of a newborn's mother was not determined during pregnancy, the provider may choose to provide education to the parent(s) or caregiver about HIV testing, and recommend HIV testing for the newborn.

Nutritional Assessment

Description

The nutritional assessment consists of documenting the child's nutritional status to determine if it is in the normal range for age and health history.

Required

The provider must assess the child's nutritional status and document the findings in the child's medical record.

Recommended

Based on the provider's medical discretion, the following elements, as appropriate for the child's age and health history, should be documented:

- Height and weight (measure and plot on a standard chart)*;
- Head circumference, if the recipient is 24 months or younger (measure and plot on a standard chart);
- Dietary intake;
- Eating habits;
- Use of alcohol, drugs, and tobacco; and
- Women, Infants and Children (WIC) participation or referral.

* **Note:** See the CDC website at www.cdc.gov/growthcharts/; AAP website at www.aap.org; and Bright Futures website at www.brightfutures.org for information on new growth charts to calculate and plot weight, height, and Body Mass Index (BMI) using age and gender-appropriate graphs; as well as, information on weight problems, such as obesity.

WIC Services

For more information on WIC services and referrals, contact the Bureau of WIC and Nutrition Services, Department of Health, at (850) 245-4202 or 800-342-3556 or contact the nutritionist at your local WIC office at the county health department.

Recipients Who Need Further Assessment

If the nutritional assessment suggests nutritional problems, the provider, based on medical discretion, may either provide or refer the child for:

- Assessment of family, socioeconomic, and community factors;
 - Assessment of the quality and quantity of child's diet (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs);
 - Physical and laboratory examinations; and
 - Preventive, treatment and follow-up services, including dietary counseling and nutritional education.
-

Required Frequency

The provider must assess and document the child's nutritional status at each Child Health Check-Up.

Developmental Assessment

Description	The developmental assessment consists of a range of activities to determine whether the child's physical, cognitive and emotional developments are within the normal range for the child's age and cultural background.
Required	The provider must assess the child's developmental status and document the findings in the child's medical record.
Recommended	<p>Based on the provider's medical discretion, the following elements, as appropriate for the child's age and cultural background, should be considered:</p> <ul style="list-style-type: none">• Gross motor development--focusing on strength, balance, and locomotion;• Fine motor development--focusing on eye-hand coordination;• Communication skills or language development--focusing on expression, comprehension and speech articulation;• Self-help and self-care skills;• Social-emotional development--focusing on the ability to engage in social interaction with other children, adolescents, parents and other adults; and• Cognitive skills--focusing on problem solving or reasoning. <p>If the child needs additional objective testing, the provider should use a developmental assessment tool that is appropriate for the child's age and cultural background.</p>
Emphasis for Young Children	For school-age children, the provider should focus on visual-motor integration, visual-spatial organization, visual-sequential memory, attention skills, auditory processing skills, and auditory sequential memory.
Emphasis for Adolescents	For adolescents, the provider should focus on areas of special concern, such as potential learning disabilities, peer relations, psychological issues, psychiatric problems and vocational skills.
Recipients Who Need Further Assessment	The provider should refer a child who needs further assessment to the Early Intervention Program through the local Children's Medical Services office or the local Florida Diagnostic and Learning Resources System (FDLRS). FDLRS can be contacted through the local school system.
Required Frequency	The provider must assess and document the child's developmental status at each Child Health Check-Up.

Comprehensive Unclothed Physical Examination

Description The physical examination consists of a comprehensive, unclothed examination to determine whether the child's physical development is within the normal range for the child's age and health history. An infant must be undressed, and an older child must be undressed and suitably draped.

Required The provider must perform a comprehensive unclothed physical examination and document the findings in the child's medical record.

Recommended Effective October 16, 2003 Based on the provider's medical discretion, the following elements as appropriate for the child's age and health history should be addressed:

- Appearance
- Skin
- Head
- Eyes, ears, nose, mouth, throat, teeth, gums
- Nodes
- Blood pressure beginning at three years of age and as indicated
- Heart and femoral pulses
- Pulse and respiration
- Lungs
- Abdomen
- External genitalia
- Pelvic examination on all sexually active females, and if not sexually active, may wish to consider beginning at age 18*
- Hip abduction
- Gait
- Extremities
- Spine
- Neurological evaluation

* Note: Provider may wish to refer female recipients for this service.

Required Frequency The provider must perform and document a comprehensive, unclothed physical examination at each Child Health Check-Up.

Dental Screening

Description The dental screening component of the comprehensive physical examination should consist of an examination to check for obvious abnormalities, such as cavities, inflammation, infection or malocclusion. Dental referrals are required beginning at 3 years of age; earlier as medically indicated.

Required The provider must assess the child's dental status and document the findings (under comprehensive physical examination) in the child's medical record.

Required Dental Referral for Recipients Three Years Old and Older The provider must refer children who are 3 years old and older for an assessment by a dentist and document this referral in the child's medical record. The provider may refer a younger child if it is medically necessary.

Recommended Following the initial dental referral, subsequent examinations by a dentist are recommended every 6 months, or more frequently as prescribed by a dentist or other authorized provider.

If a dental provider is not available in an area, children must still be referred to a dentist. Providers should notify the area Medicaid office that the child needs a dental visit.

Required Frequency The provider must assess and document the child's dental status at each Child Health Check-Up.

Sensory Screenings

Vision Screening Description Vision must be assessed and documented as part of the comprehensive physical examination with age appropriate testing to determine if the child's vision is within the normal range.

[Note: AAP website at www.aap.org for information on vision screening.]

Required Effective October 16, 2003 The provider must assess (including an ophthalmoscopic examination) the child's vision status, and document the findings in the child's medical record.

Sensory Screenings, continued

Required Schedule for Objective Vision Testing

The provider must perform age appropriate objective vision testing on children who are 3 years old and older and document the results in the child's medical record.

Objective vision testing must be performed at a minimum when the child is the following ages:

- 3 years*
- 4 years*
- 5 years*
- 6 years
- 8 years
- 10 years
- 12 years
- 15 years
- 18 years

* Document in the medical record if the child is uncooperative, and re-screen at the next Child Health Check-Up, or sooner if medically indicated.

Required Frequency

The provider must assess and document the child's vision status at each Child Health Check-Up.

Hearing Screening Description

Hearing must be assessed and documented as part of the comprehensive physical examination with age appropriate testing in order to determine if the child's hearing is within the normal range.

Required Effective October 16, 2003

The provider must assess (including an otoscopic examination) the child's hearing status and document the findings in the child's medical record.

Note: AAP website at www.aap.org for information on hearing screening.

Sensory Screenings, continued

Required Schedule for Objective Hearing Tests

The provider must perform age appropriate objective hearing testing on children who are 4 years old and older and document the results in the child's medical record.

Objective hearing testing must be performed at a minimum when the child is the following ages:

- 4 years*
- 5 years*
- 6 years
- 8 years
- 10 years
- 12 years
- 15 years
- 18 years

* Document in the medical record if the child is uncooperative, and re-screen at the next Child Health Check-Up, or sooner if medically indicated.

Required Frequency

The provider must assess and document the child's hearing status at each Child Health Check-Up.

Laboratory Tests

Description

Laboratory tests consist of testing and assessing children for the presence of diseases.

Required Test

Providers must perform the required blood lead testing, as described in this chapter, and document the results in the child's medical record.

Laboratory Tests, continued**Recommended Tests**

Providers should use their medical discretion in determining the applicability of the laboratory tests or analyses to be performed. The following tests are recommended by the Committee on Practice and Ambulatory Medicine's "Recommendations for Preventive Pediatric Health Care":

- Hematocrit or Hemoglobin
- Pap smear
- Serum cholesterol screening
- Sexually transmitted disease screening
- Sickle cell test
- Tuberculin (TB) skin testing
- Urinalysis
- Other tests, as indicated, such as stool for ova and parasites

Note: See Appendix D "Recommendations for Preventive Pediatric Health Care."

Contraindicated Tests

If any laboratory tests or analyses are medically contraindicated at the time of screening, the provider should postpone it until the test is no longer medically contraindicated.

Hematocrit or Hemoglobin Test

Hematocrit or hemoglobin tests are recommended at the following ages with results documented in the child's medical record:

- 9 months
- 15 months*
- 13 years

* Recommended for children at risk.

All menstruating adolescents should be screened annually. Other children should be tested when medically indicated.

Required Blood Lead Testing

Federal regulation requires that all children receive a screening blood lead test at:

- 12 months of age; and at
 - 24 months of age; and
 - Children between the ages of 36 and 72 months who have not been previously screened for lead poisoning.
-

Laboratory Tests, continued

Recommended Lead Poisoning Risk Assessment

Although no longer required, it is recommended that providers use a verbal lead risk questionnaire to assess risk on children who are six months to six years of age.

See Appendix F for the Department of Health's, Childhood Lead Poisoning Surveillance Program's recommended questionnaire, "Lead Poisoning Risk Assessment."

For a complete copy of the Florida Department of Health's recommended statewide childhood lead poisoning screening guidelines, as referenced on the Lead Poisoning Risk Assessment, please contact the department below:

Florida Department of Health HSEE
Childhood Lead Poisoning Surveillance Program
4052 Bald Cypress Way, Bin #A08
Tallahassee, FL 32399-1712

Telephone Number: (850) 245-4299 and FAX: (850) 922-8473

Blood Lead Test Results

A blood lead test result equal to or greater than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$) obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

Note: Refer to Chapter 3 for reimbursement information on blood lead testing.

Diagnosis, Treatment and Follow-up

If a child is found to have blood lead levels equal to or greater than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$), providers should use their medical discretion, with reference to the current CDC guidelines covering patient management and treatment, including follow-up blood tests and initiating investigations as to the source of lead where indicated.

Note: For additional information on lead screening, contact the Department of Health, Bureau of Toxicology at (850) 245- 4299, the Department of Health, Bureau of Environmental Epidemiology at (850) 245-4299, or the CDC at (404) 639-3311. For free publications on Childhood Lead Poisoning contact the CDC at toll free (888) 232-6789.

Pap Smear

A routine pap smear is recommended as part of preventive health maintenance on all sexually active female recipients, and if not sexually active, beginning at age 18.

Laboratory Tests, continued**Serum Cholesterol**

A serum cholesterol determination is recommended on children with a family history of early heart disease, hypertension or stroke. (See the American Academy of Pediatrics' website at www.aap.org for information on Cholesterol and the 1998 Policy Statement on Cholesterol in Childhood [RE9805].)

Sexually Transmitted Disease Screening

Screening all sexually active recipients for sexually transmitted diseases is recommended. Chlamydia screening is recommended for at-risk adolescents. Refer to the CDC for more information on the high prevalence of chlamydia infection. The CDC website address is: www.epo.cdc.gov/wonder/prevguid/p0000222/entire.htm. The urine screen for chlamydia is an acceptable method for chlamydia screening.

Sickle Cell Test

Since August 1988, almost all infants born in Florida are screened for the presence of sickle cell. If a child has been properly tested once for sickle cell disease, the test need not be repeated.

There may be instances where providers may consider performing hemoglobin electrophoresis on children born prior to 1988 or who have not been previously tested for sickle cell and document the results in the child's medical record.

The Children's Medical Services, Florida Infant Screening program provides follow-up on abnormal test results for sickle cell disease and other significant hemoglobinopathies.

Tuberculin (TB) Skin Testing Effective October 16, 2003

Providers should assess the child's risk for latent TB infection and document the results in the child's medical record. The following questions should be asked about each child to determine whether the child needs to be assessed for active TB disease or TB infection:

- Does the child exhibit signs or symptoms of tuberculosis (e.g., cough, weight loss, loss of appetite)?
- Has the child had close contact with an active TB case?
- Was any household member including the child born in or frequently traveled to or had visitors staying in the child's home from areas where TB is endemic (e.g., Asia, Africa, Latin America, Caribbean, Eastern Europe)?
- Does the child have frequent contact with adults at high-risk for TB disease (e.g., HIV+, homeless, incarcerated, illicit drug user, local high-risk groups)?
- Is the child HIV+ or have any other condition that may cause immunosuppression?

Laboratory Tests, continued

**Tuberculin (TB)
Skin Testing
Effective
October 16, 2003,
continued**

A “Yes” response to any question indicates that the child may be at high risk and needs further assessment, e.g., symptom questionnaire, Mantoux tuberculin skin test.

Children in these groups who are at high risk for TB, who do not have or are not suspected of having active disease, and found to be infected with latent TB infection should be seriously considered for treatment for their latent TB infection and followed closely to ensure completion of this treatment.

Providers should consider referencing the recommendations of the current American Academy of Pediatrics Committee on Infectious Disease, Red Book, the Centers for Disease Control and Prevention (CDC). For local and state specific information on TB skin testing including risk factors as well as information about TB infection and TB disease, contact your local county health department, the Florida TB Physicians Network at 1-800-4TB-INFO, or Florida’s Department of Health, Bureau of TB and Refugee Health at (850) 245-4350.

Note: References: ATS/CDC. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. Am J Respir Crit Care Med Vol 161. pp S221–S247, 2000. Ozuah, P.O., et.al. Evaluation of a Risk Assessment Questionnaire Used to Target Tuberculin Skin Testing in Children. JAMA. 2001;285:451-453

Urinalysis

Urinalysis is recommended for children when they are 5 and 16 years of age, and as indicated.

Performing dipstick urinalysis for leukocytes is recommended annually for sexually active male and female adolescents.

Immunizations

Description

Providers must assess and document in the child's medical record the child's immunization status, as appropriate for age and health history.

Required

If it is determined at the time of the Child Health Check-Up that an immunization(s) is needed and appropriate (for age and health history) to provide during the check-up, then immunization(s) must be provided at that time.

Recommended

If the child's immunizations are not up to date according to age and health history, providers should document why immunizations were not given at the time of the Child Health Check-Up.

Note: See Chapter 3 for information on reimbursement for immunizations.

Immunization Schedule

Child Health Check-Up providers should use the most current Recommended Childhood Immunization Schedule developed and endorsed by the Advisory Committee on Immunization Practices, the Committees on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians.

Note: The most current schedule is available on the Internet at www.cdc.gov/nip. (Click on publications.) Providers may also obtain the current schedule from their County Health Departments. The CDC's National Immunization Information Hotline is 1-800-232-2522 and in Spanish is 1-800-232-0233.

Required Frequency

The provider must assess and document the child's immunization status at each Child Health Check-Up.

Health Education, Anticipatory Guidance

Description

Health education consists of informing the child and the parent or caregiver about the benefits of healthy lifestyles and practices, and how to prevent accidents and diseases. It also includes anticipatory guidance to explain misconceptions, introduce new information, and reinforce what the family is doing well.

Required Effective October 16, 2003

The provider must provide age appropriate health education including anticipatory guidance to all children and their parents or caregivers and document in the child's medical record that health education was provided.

Providers must also provide age-appropriate health education regarding smoking and smoking cessation.

Recommended Effective October 16, 2003

In addition to general health education including anticipatory guidance, the following are recommended as appropriate for age and health history:

- For children from 6 months to 72 months of age regardless of the risk for lead poisoning, give detailed lead poisoning prevention counseling including ways to reduce lead exposure through nutrition, personal hygiene, and household hygiene.
 - For the school-age children, address behavioral risk on topics such as smoking, substance abuse, sexual activity as appropriate, and absenteeism.
 - Address injury prevention such as use of car seats, seat belts, bike helmets, and water safety.
 - Provide guidance on violence prevention including counseling on conflict resolution, negotiation and dealing with anger constructively.
 - Counsel on sun protection.
 - Counsel on STDs and HIV.
 - Counsel on sleep positioning.
 - Counsel on nutrition.
 - Counsel on the importance of physical activity.
-

Note: Bright Futures Anticipatory Guidelines is available at www.brightfutures.org; see the AAP website at www.aap.org.

Required Frequency

The provider must provide and document health education including anticipatory guidance at each Child Health Check-Up.

CHAPTER 3
CHILD HEALTH CHECK-UP
PROCEDURE CODES, DIAGNOSIS CODES,
REFERRAL CODES, AND REIMBURSEMENT

Overview

Introduction

This chapter explains the Child Health Check-Up procedure codes, diagnosis codes, referral codes, and reimbursement.

In This Chapter

This chapter contains:

TOPIC	PAGE
Procedure Code Information	3-2
Diagnosis Code Information	3-3
Referral Code Information	3-4
Reimbursement Information	3-4

Procedure Code Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. Codes described in the Physician's Current Procedure Terminology (CPT) book are part of the HCPCS code system. Please refer to the CPT book for complete descriptions of the standard codes.

Effective with dates of service on or after October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service beginning October 16, 2003. For dates of service prior to October 16, 2003, the provider must use procedure codes that were payable at that time, which may be submitted either electronically or on a paper claim form. Please refer to the following listing for the valid codes for Florida Medicaid's Child Health Check-Up services effective October 16, 2003.

New Procedure Codes for Dates of Service Beginning October 16, 2003

The new procedure codes for a Child Health Check-Up service are the CPT Preventive Medicine Services Codes. In some cases, one or two modifiers are required to uniquely identify the service provided. Both the procedure code and modifiers listed must be completed on the claim in order to receive proper reimbursement. No modifiers other than the ones listed in this chapter are allowed when billing these services.

New Patient

<u>Code</u>	<u>Modifier</u>	<u>Description</u>
99381		Initial comprehensive preventive medicine evaluation and management of an infant, age under 1 year
99382		Initial comprehensive preventive medicine evaluation and management of early childhood, age 1 through 4 years
99383		Initial comprehensive preventive medicine evaluation and management of late childhood, age 5 through 11 years
99384		Initial comprehensive preventive medicine evaluation and management of an adolescent, age 12 through 17 years
99385	EP	Initial comprehensive preventive medicine evaluation and management of an 18 through 20 year old*

*Note: The EP modifier must be used with Procedure Code 99385 to identify children 18 through 20 years of age.

Procedure Code Information, continued

New Procedure Codes for Dates of Service Beginning October 16, 2003, continued	<u>Established Patient</u>		
	<u>Code</u>	<u>Modifier</u>	<u>Description</u>
	99391		Periodic comprehensive preventive medicine reevaluation and management of an infant, age under 1 year
	99392		Periodic comprehensive preventive medicine reevaluation and management of early childhood, age 1 through 4 years
	99393		Periodic comprehensive preventive medicine reevaluation and management of late childhood, age 5 through 11 years
	99394		Periodic comprehensive preventive medicine reevaluation and management of an adolescent, age 12 through 17 years
	99395	EP	Periodic comprehensive preventive medicine reevaluation and management of an 18 through 20 year old*

* **Note:** The EP modifier must be used with Procedure Code 99395 to identify children 18 through 20 years of age.

Local Code for Dates of Service through October 15, 2003	The Child Health Check-Up procedure code (W9881) and the procedure code (W9979) for Blood Lead (capillary) should be used through October 15, 2003.
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Diagnosis Code Information

Diagnosis Codes Required	<p>Diagnosis codes are found in the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM). The provider must enter the most specific diagnosis code(s) including the fourth and fifth digits, when available, on the claim form.</p> <p>A diagnosis code is required for reimbursement of a Child Health Check-Up service. See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for paper claim submission. For electronic claim submission, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.</p>
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Referral Code Information

Required Child Health Check-Up Referral Codes

For Child Health Check-Up screening services, enter the referral code that identifies the health screening of the child:

U	Complete Normal Indicator is used when there are no referrals made.
2	Abnormal, Treatment Initiated Indicator is used when a child is currently under treatment for referred diagnostic or corrective health problem.
T	Abnormal, Recipient Referred Indicator is used for referrals to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic check-up (not including dental referrals).
V	Patient Refused Referral Indicator is used when the patient refused a referral.

Note: See specific instructions for using these codes in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for paper claim submission and for electronic claim submission, contact the Medicaid fiscal agent EDI help desk at 800-829-218.

Reimbursement Information

Child Health Check-Up Claim Form with HIPAA Implementation

For paper claim submission, beginning with HIPAA implementation, a Child Health Check-Up service must be billed on the CMS-1500 claim form.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions on completing the claim form.

Note: For electronic claim submission, beginning with HIPAA implementation, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Child Health Check-Up Reimbursement

To be reimbursed, Child Health Check-Up providers must assess and document in the child's medical record all the required components of a Child Health Check-Up (see Chapter 2 for the required components of a Child Health Check-Up). Medicaid reimburses on an all-inclusive fee basis for a Child Health Check-Up, except for immunizations and laboratory services.

All providers may be reimbursed for immunization services, in addition to a Child Health Check-Up. Certain providers may also be reimbursed for blood lead testing and other laboratory services. Reimbursement for immunizations and laboratory services is described as follows.

Reimbursement Information, continued

Immunization Services Reimbursement

In addition to a Child Health Check-Up, providers may be reimbursed for immunization services through their provider-specific Medicaid programs, such as physician services. The provider may bill for immunization services on the CMS-1500 claim form in addition to a Child Health Check-Up service.

Note: See the service-specific coverage and limitations handbook for information on reimbursement for immunization services.

Tuberculin Skin Test Reimbursement

In addition to the Child Health Check-Up, providers may be reimbursed for tuberculin skin tests through their provider-specific Medicaid programs, such as physician services. The provider may bill for the tests on the CMS-1500 claim form in addition to a Child Health Check-Up service.

Note: See the service-specific coverage and limitations handbook for information on reimbursement for tuberculin skin tests.

Laboratory Tests Reimbursement

In addition to a Child Health Check-Up, certain providers may be reimbursed for laboratory testing, including dipstick urine and finger stick hemoglobin and hematocrit, through their provider-specific Medicaid programs, such as physician services. The provider-specific Medicaid program must allow reimbursement for laboratory tests. Medicaid does not reimburse for the collection and handling of specimens during a physician's office visit.

To perform laboratory tests and analyze the results, the provider's office laboratory must be certified by the Clinical Laboratories Improvement Amendment of 1988 (CLIA).

The provider may bill for laboratory tests on the CMS-1500 claim form in addition to a Child Health Check-Up service.

County health departments and federally qualified health centers may not be reimbursed for laboratory tests in addition to their encounter rate for a Child Health Check-Up.

Reimbursement Information, continued

Blood Lead Test Reimbursement

In addition to a Child Health Check-Up, certain providers may be reimbursed for blood lead testing through their provider-specific Medicaid programs, such as physician services. The provider-specific Medicaid program must allow reimbursement for blood lead testing.

Effective for Dates of Service beginning October 16, 2003

The provider may be reimbursed for a blood lead test by using procedure code 83655 for a venous or for capillary specimens.

The provider may bill for blood lead testing on the CMS-1500 claim form in addition to a Child Health Check-Up service.

County health departments and federally qualified health centers may not be reimbursed for blood lead testing in addition to their encounter rate for a Child Health Check-Up.

Please refer to the Independent Laboratory Services Coverage and Limitations Handbook for further information.

Providers Who Cannot Perform Laboratory Tests

Providers who cannot perform laboratory tests may refer children to a Medicaid participating independent laboratory to have the sample or specimen drawn and analyzed. The independent laboratory can bill Medicaid. Please instruct the laboratory to enter "Child Health Check-Up related" by checking the EPSDT box in item 24H on the CMS-1500 claim form.

Child Health Check-Up by an ARNP, PA, or Licensed Midwife

Child Health Check-Ups that are performed by advanced registered nurse practitioners (ARNPs), physician assistants (PAs), and licensed midwives are reimbursed at 80 percent. The ARNP's, PA's, or licensed midwife's provider number must be entered as the treating provider in item 24K on the CMS-1500 claim form for paper claims.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions on completing the claim form for paper claims. For electronic claim submission, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

APPENDIX A

CHILD HEALTH CHECK-UP PROVIDER TYPES AND MAXIMUM FEES

Provider Type and Maximum Fee

Provider Types

The maximum fee varies by provider type. Child Health Check-Up reimbursement is the same for each of the ten CPT Preventive Medicine Services Codes listed (99381-99385EP and 99391-99395EP) in Chapter 3, of this Handbook.

Effective For Dates of Service March 1, 2003	Provider Types	Maximum Fee
	Physician Advanced Registered Nurse Practitioner Physician Assistant Licensed Midwife Birthing Centers	\$71.47 \$57.17 \$57.17 \$52.87 \$66.09
	County Health Department, Federally Qualified Health Center, and Rural Health Clinic	Clinic-specific encounter rate

APPENDIX B
CHILD HEALTH CHECK-UP TRACKING FORMS

1 to 14 Day Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

PRENATAL HISTORY

FIRST PRENATAL VISIT DATE	ALCOHOL, AMOUNT	TOBACCO, AMOUNT	STREET DRUGS
STDs (specify)	HEPATITIS B	HIV	OTHER MATERNAL PROBLEMS
WEEKS GESTATION	<input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN	BIRTH WEIGHT	WHERE DELIVERED

PERINATAL HISTORY

DEFORMITIES/APGAR	ABNORMALITIES	OTHER	DATE OF D/C - LOS
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INTERVAL HISTORY

PAST MEDICAL HISTORY WNL	<input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST <input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON
---	--	---

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen inc. cord			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

--

SENSORY SCREEN

NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (responds to noises, startles) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
--	---

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, moro reflex)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

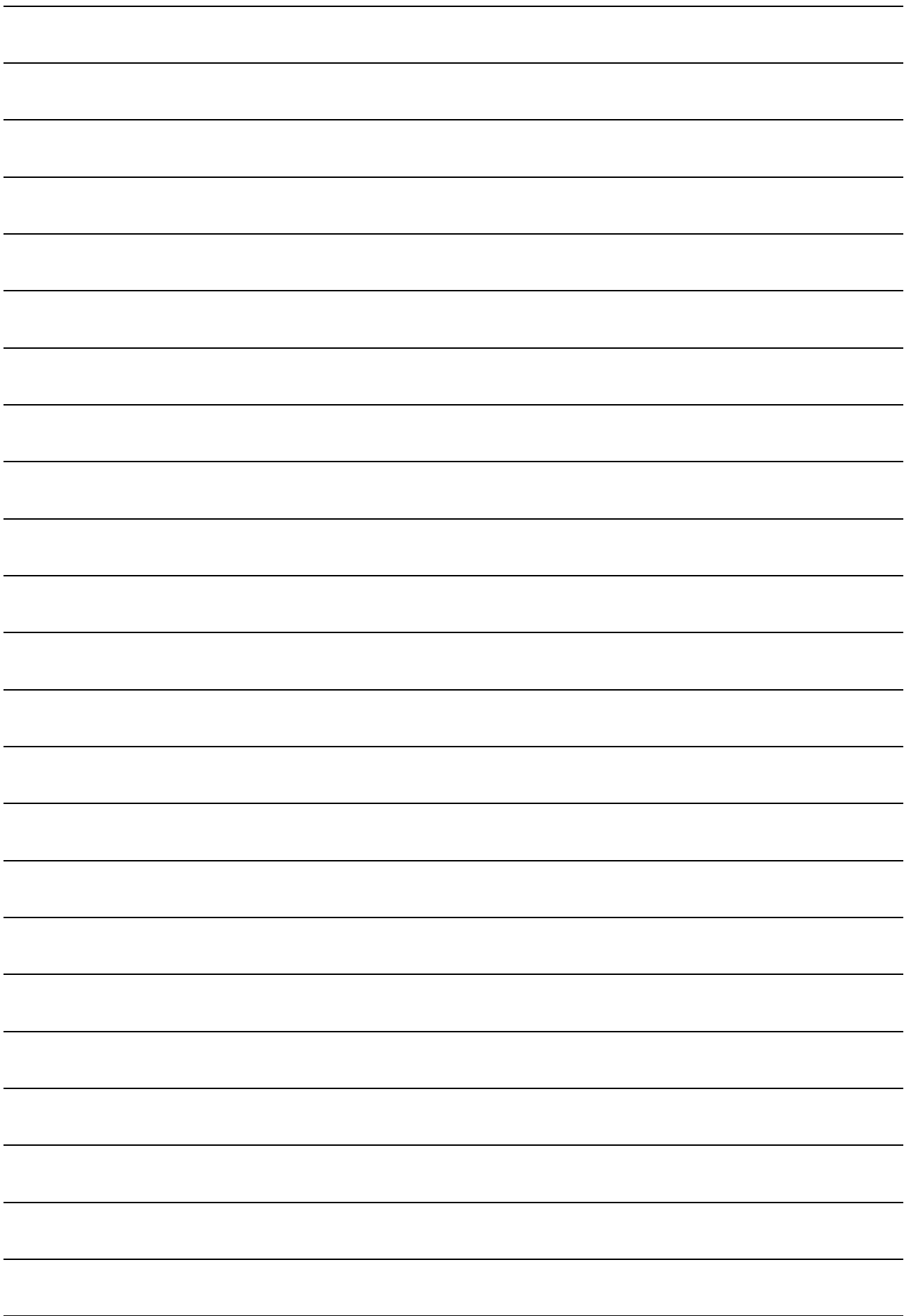
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> "BACK TO SLEEP" <input type="checkbox"/> OTHER
--

DIAGNOSIS:
PLAN:
SIGNATURE:



2 Weeks to 2 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS	<input type="checkbox"/> IRON	<input type="checkbox"/> SOLIDS
---------------------------------	-----------------------------------	--	-----------------------------------	-------------------------------	---------------------------------

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

--

SENSORY SCREEN

NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (responds to noises, startles at loud noises) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
--	--

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, regards face, moro reflex)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---	---

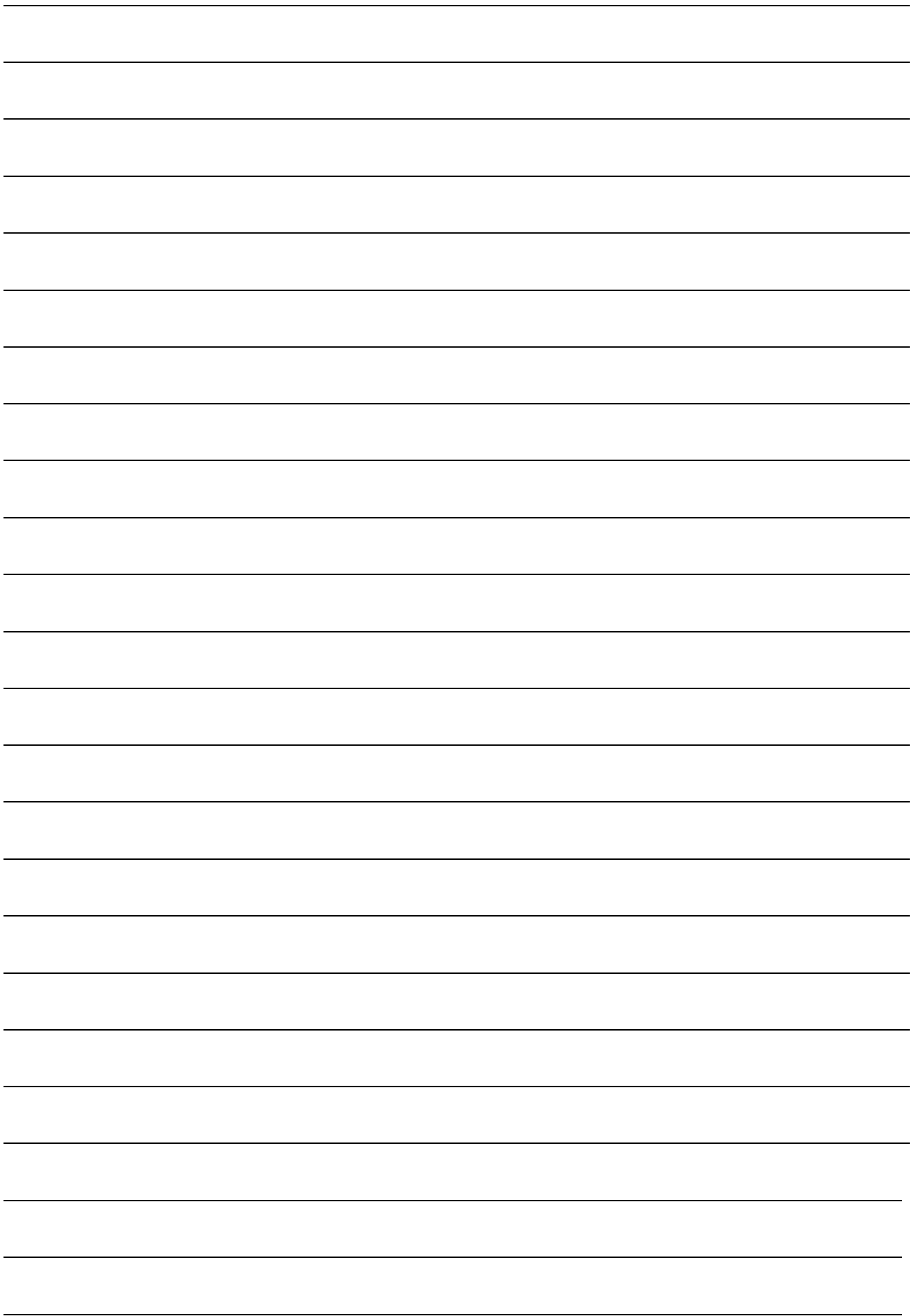
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> TALK TO BABY <input type="checkbox"/> FEVER EDUCATION <input type="checkbox"/> SAFETY - ROLLING OVER <input type="checkbox"/> OTHER
--

DIAGNOSIS:
PLAN:
SIGNATURE:



2 to 4 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON <input type="checkbox"/> SOLIDS
---------------------------------	-----------------------------------	--	-----------------------------------	---

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

--

SENSORY SCREEN

NORMAL VISION? (red reflex, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., smiles and/or turns toward speech or sound, coos) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---	---

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts chest, hands at midline, smiles spontaneously, rolls over one way, grasps rattle)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

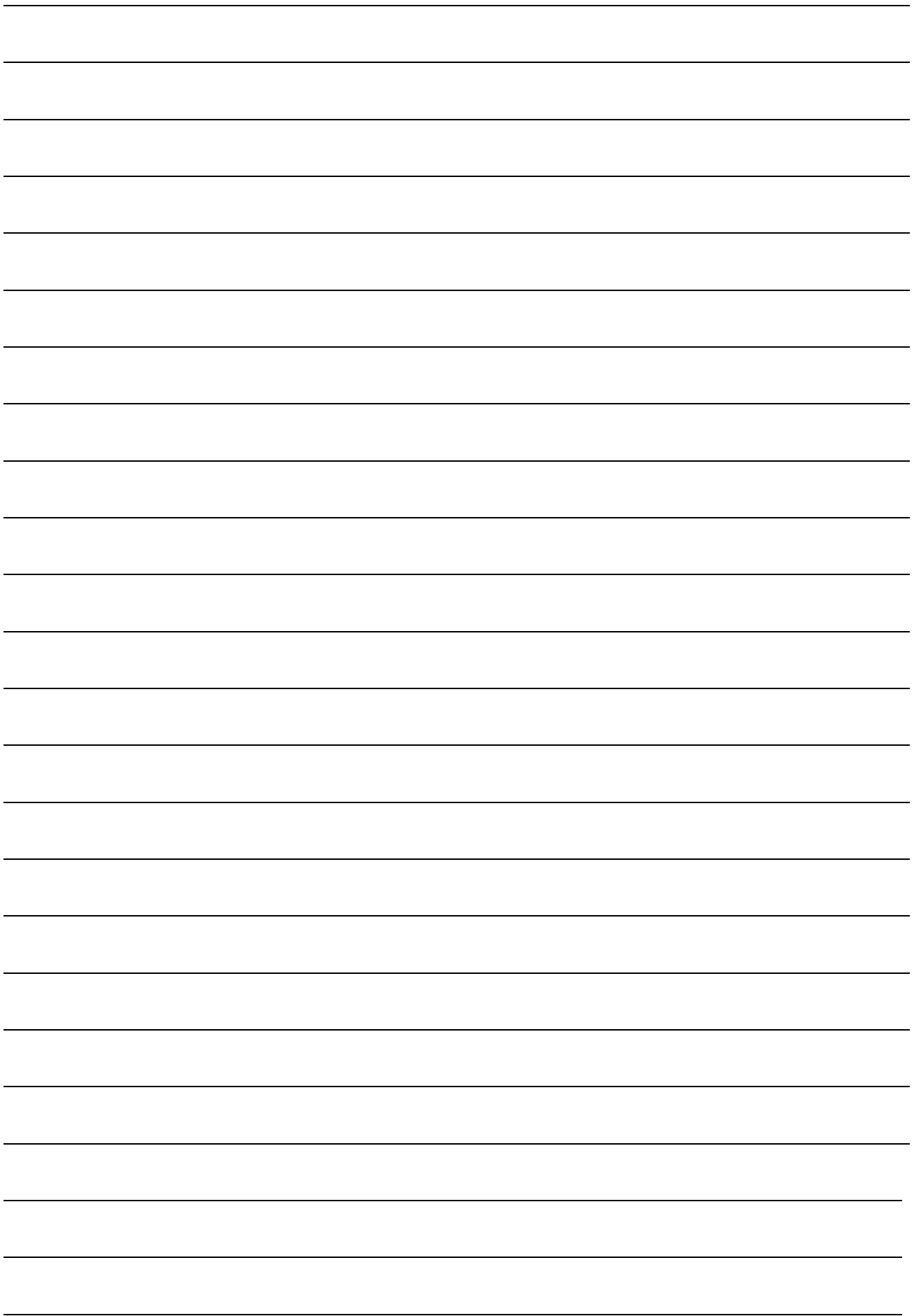
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> SOLID FOODS	<input type="checkbox"/> CHOKING, ASPIRATION	<input type="checkbox"/> FALLS
<input type="checkbox"/> TEETHING	<input type="checkbox"/> BABY-PROOF HOME	<input type="checkbox"/> "BACK TO SLEEP"

DIAGNOSIS:
PLAN:
SIGNATURE:



4 to 6 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS	<input type="checkbox"/> IRON	<input type="checkbox"/> SOLIDS
---------------------------------	-----------------------------------	--	-----------------------------------	-------------------------------	---------------------------------

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
--	--

SENSORY SCREEN

NORMAL VISION? (red reflex, cover-uncover test, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., responds to sound, repeats sounds) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---	--

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone-i.e., rolls over, reaches for objects, laughs, squeals)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

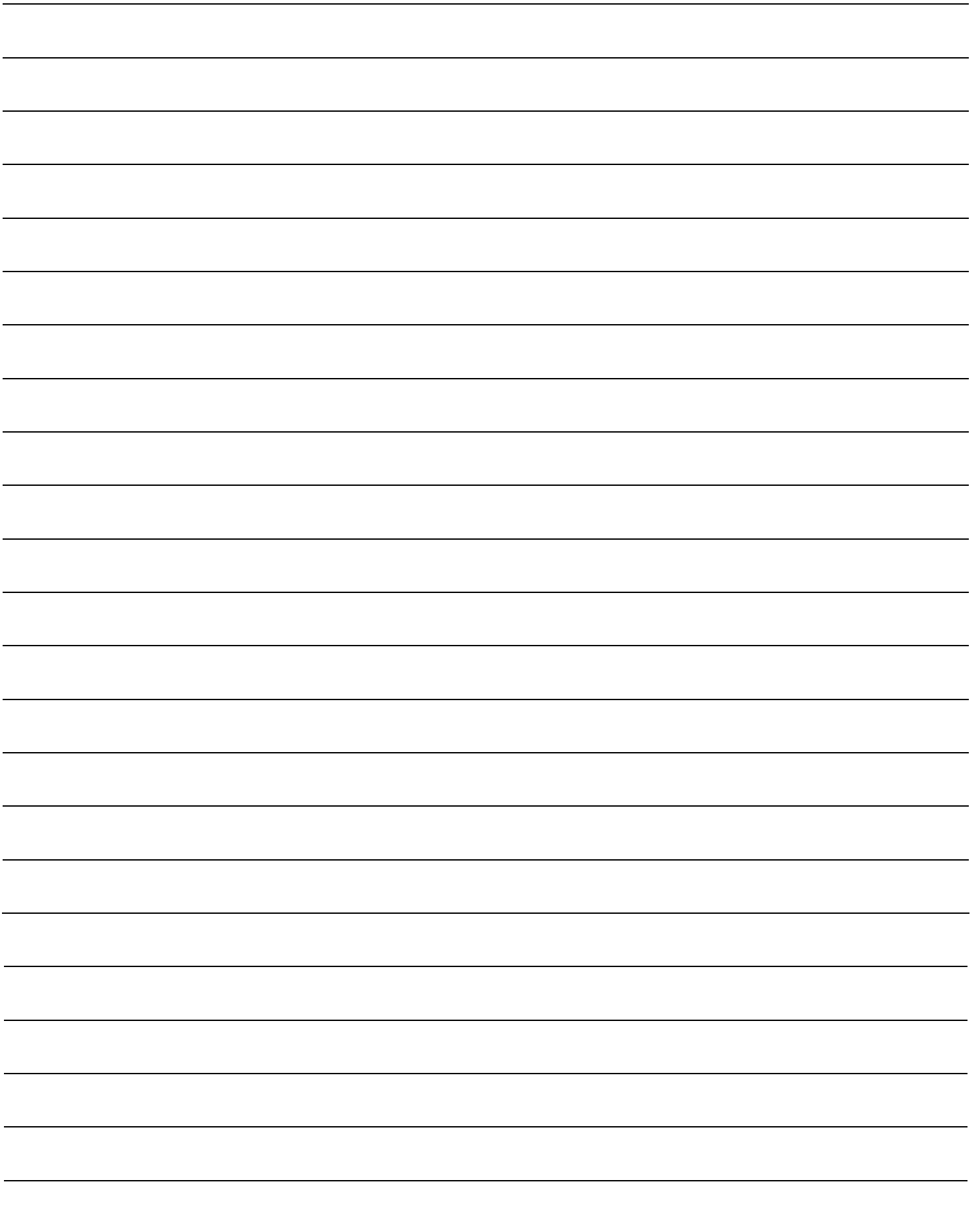
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> CUP, FINGER FOODS	<input type="checkbox"/> NO BOTTLE IN BED	<input type="checkbox"/> TEETHING
<input type="checkbox"/> POOL & TUB SAFETY	<input type="checkbox"/> POISONS	<input type="checkbox"/> OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:



6 to 12 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS SOLIDS	<input type="checkbox"/> IRON	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/>
---------------------------------	-----------------------------------	--	--	-------------------------------	-----------------------------------	--------------------------

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> Hgb/Hct _____ (9 mo, adolescent females & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
--	--	--

SENSORY SCREEN

NORMAL VISION? (red reflex, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 9 mo. Turns when called, listens to people talking, enjoys imitating sounds; by 12 mo. Responds to "no", follows simple commands, gives objects upon request, 1-3 words) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
---	---

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 9 mo. Plays peek-a-boo, gets to sitting, pulls self to stand, thumb-finger grasp, bangs two toys together; by 12 mo. Play pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
--

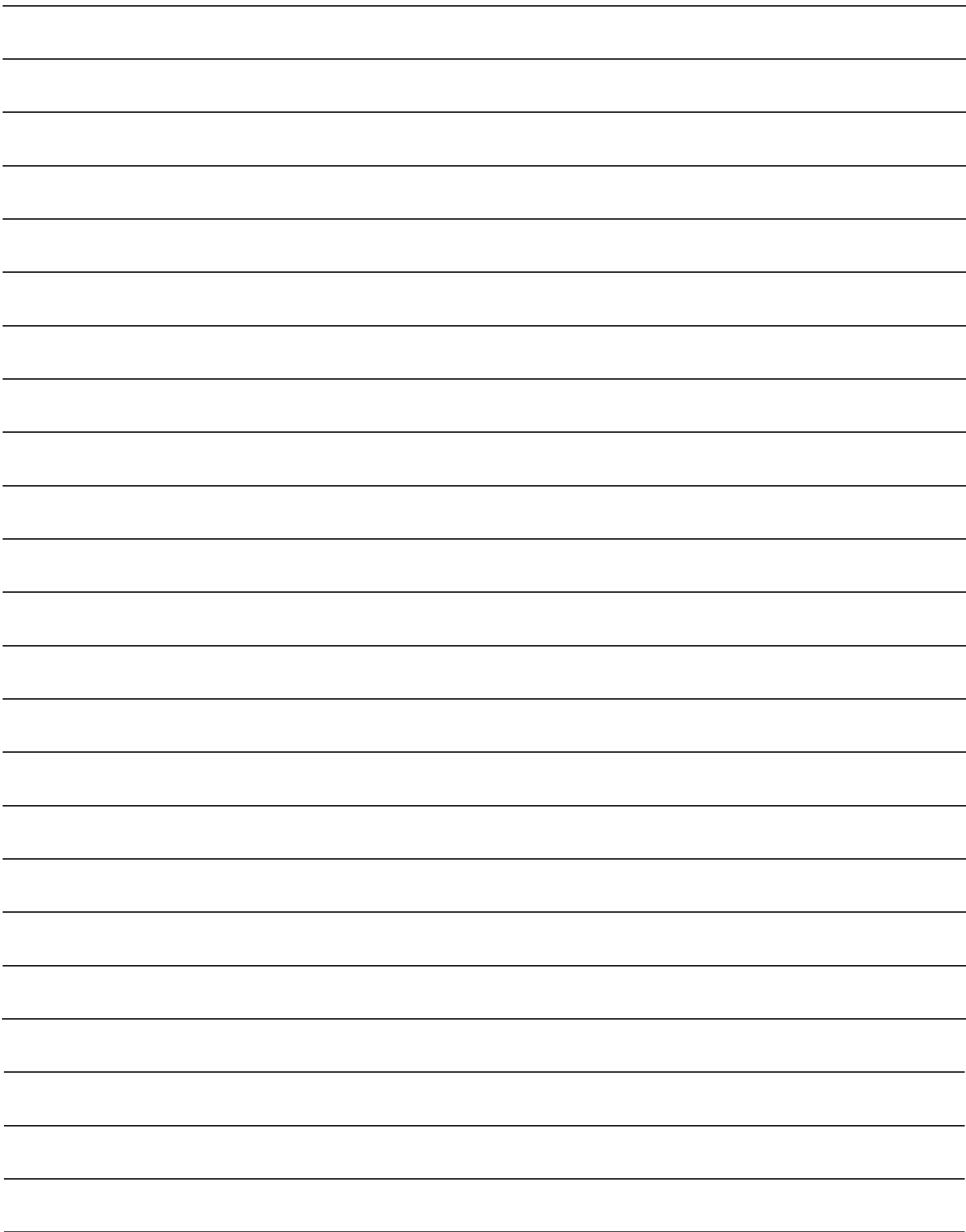
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> BABY-PROOF HOME, POOL	<input type="checkbox"/> SELF-FEEDING	<input type="checkbox"/> TALK TO CHILD
<input type="checkbox"/> TALK TO & NAME OBJECTS	<input type="checkbox"/> SLEEPING	<input type="checkbox"/> DISCIPLINE, PRAISE
<input type="checkbox"/> SHOES-PROTECT, NOT SUPPORT	<input type="checkbox"/> DENTAL HYGIENE	
<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> OTHER	

DIAGNOSIS:
PLAN:
SIGNATURE:



12 to 18 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> WHOLE MILK:	<input type="checkbox"/> CUP	<input type="checkbox"/> BOTTLE:	<input type="checkbox"/> TABLE FOODS
WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS	<input type="checkbox"/> IRON	<input type="checkbox"/> FLUORIDE	

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc. Or Gait			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
--	--

SENSORY SCREEN

NORMAL VISION? (red reflex, follows, cover-uncover) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 12 mo. Responds to "no", follows simple commands, gives objects upon request, 1-3 words; by 18 mo. Reacts to music, points to named objects, 2-3 words other than mama-dada, points to one named body part) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 12 mo. Play pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points; by 18 mo. Uses spoon, kicks/throws ball, walks alone)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

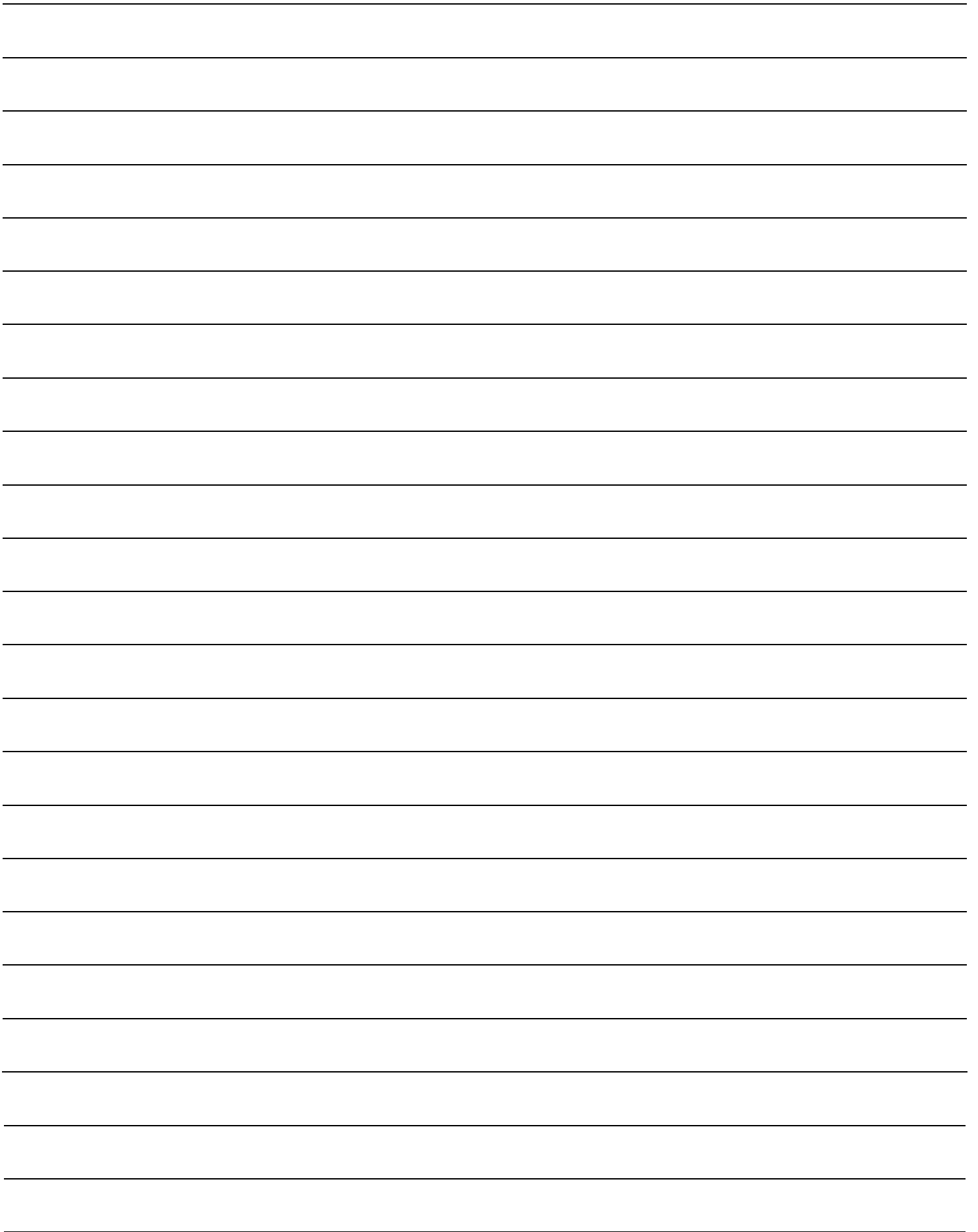
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> SAFETY <input type="checkbox"/> DISCIPLINE/LIMITS <input type="checkbox"/> TANTRUMS <input type="checkbox"/> EATING <input type="checkbox"/> SLEEPING <input type="checkbox"/> READ TO CHILD <input type="checkbox"/> ASPIRATION <input type="checkbox"/> NO BOTTLE <input type="checkbox"/> SNACKS <input type="checkbox"/> TOILET TRAINING <input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> OTHER <input type="checkbox"/> SUN PROTECTION <input type="checkbox"/> SIBLING INTERACTION
--

DIAGNOSIS:
PLAN:
SIGNATURE:



18 Month to 3 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	WIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
Referred	

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
--------	--------	--------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
--	--

SENSORY SCREEN

NORMAL VISION? (eyes straight?, red reflex, fixation test, cover-uncover test) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (2 yr. Uses some understandable speech, combines 2 words, names objects: 3 yr. Uses 3-4 word sentences) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 18 mo. Uses spoon, kicks/throws ball, walks alone; by 3 years jumps in place; knows name, age, and sex; copies a circle)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

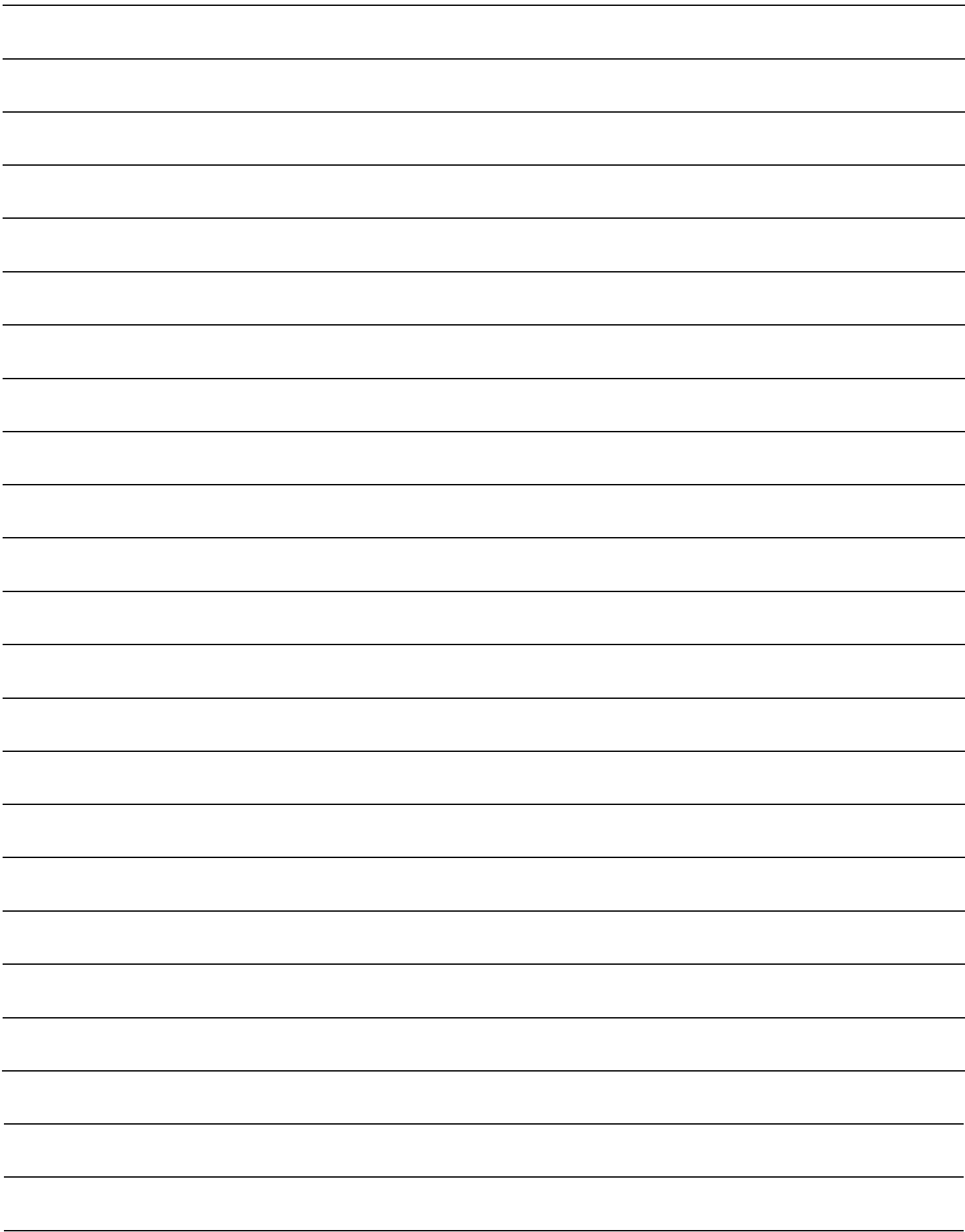
HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DECREASED APPETITE <input type="checkbox"/> READ TO CHILD <input type="checkbox"/> TOILET TRAINING
<input type="checkbox"/> TEETH BRUSHING <input type="checkbox"/> CONTROL TV VIEWING <input type="checkbox"/> SAFETY-CARS & POOL <input type="checkbox"/> SUN PROTECTION <input type="checkbox"/> OTHER

DIAGNOSIS:

PLAN:

SIGNATURE:



3 to 5 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	WIC <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
<input type="checkbox"/> Referred			

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
--------	--------	----------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> U/A _____ (5 yrs & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not screened: verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
---	---	--

SENSORY SCREEN

NORMAL <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)	<input type="checkbox"/> REFERRED
VISION? <input type="checkbox"/> REFERRED RIGHT ____ LEFT ____ BOTH ____		
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

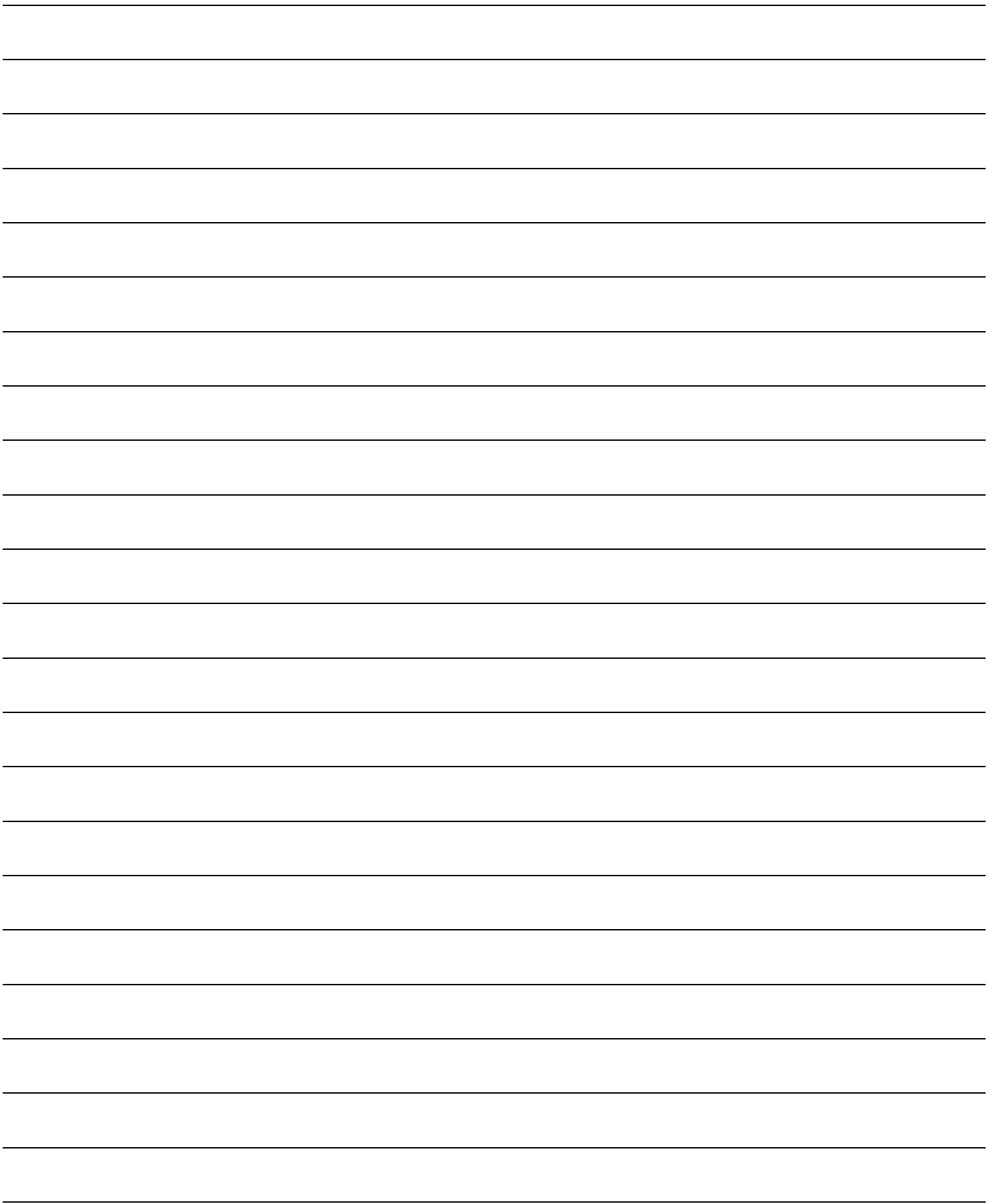
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> NO PLAYING WITH MATCHES <input type="checkbox"/> SEAT BELTS <input type="checkbox"/> STREET SAFETY
<input type="checkbox"/> PRESCHOOL <input type="checkbox"/> SEXUAL CURIOSITY

DIAGNOSIS:
PLAN:
SIGNATURE:



5 to 9 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
--	-----------------------------------	-----------------------------------

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
--------	--------	----------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> U/A _____ (5 yrs & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not screened: verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
---	---	--

SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS: RIGHT ____ LEFT ____ BOTH ____	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)	<input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
--

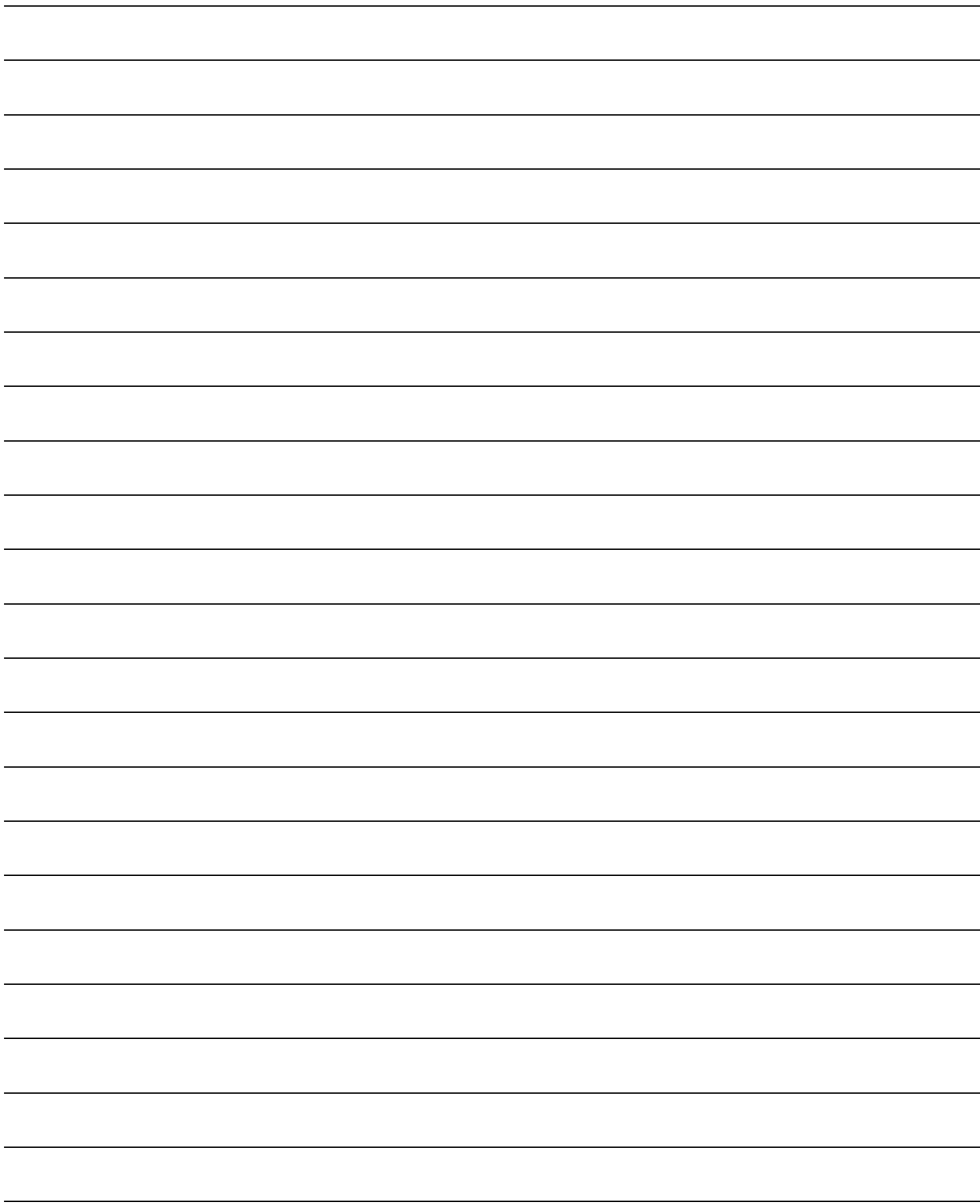
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> PEER RELATIONS <input type="checkbox"/> LIMIT SETTING <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION <input type="checkbox"/> PARENTAL ROLE MODEL <input type="checkbox"/> REGULAR PHYSICAL ACTIVITY <input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SAFETY: WATER, SEAT BELTS, SKATE BOARD, BICYCLE
--

DIAGNOSIS:
PLAN:
SIGNATURE:



9 to 13 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) _____ (First) _____		ID _____	DATE OF BIRTH _____
DATE _____	AGE _____	ACCOMPANIED BY _____	RELATIONSHIP _____

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
--	-----------------------------------	-----------------------------------

PHYSICAL EXAM

HEIGHT _____	WEIGHT _____	BLOOD PRESSURE _____
--------------	--------------	----------------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

--

SENSORY SCREEN

NORMAL <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)
VISION? <input type="checkbox"/> REFERRED RIGHT ____ LEFT ____ BOTH ____	<input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
--

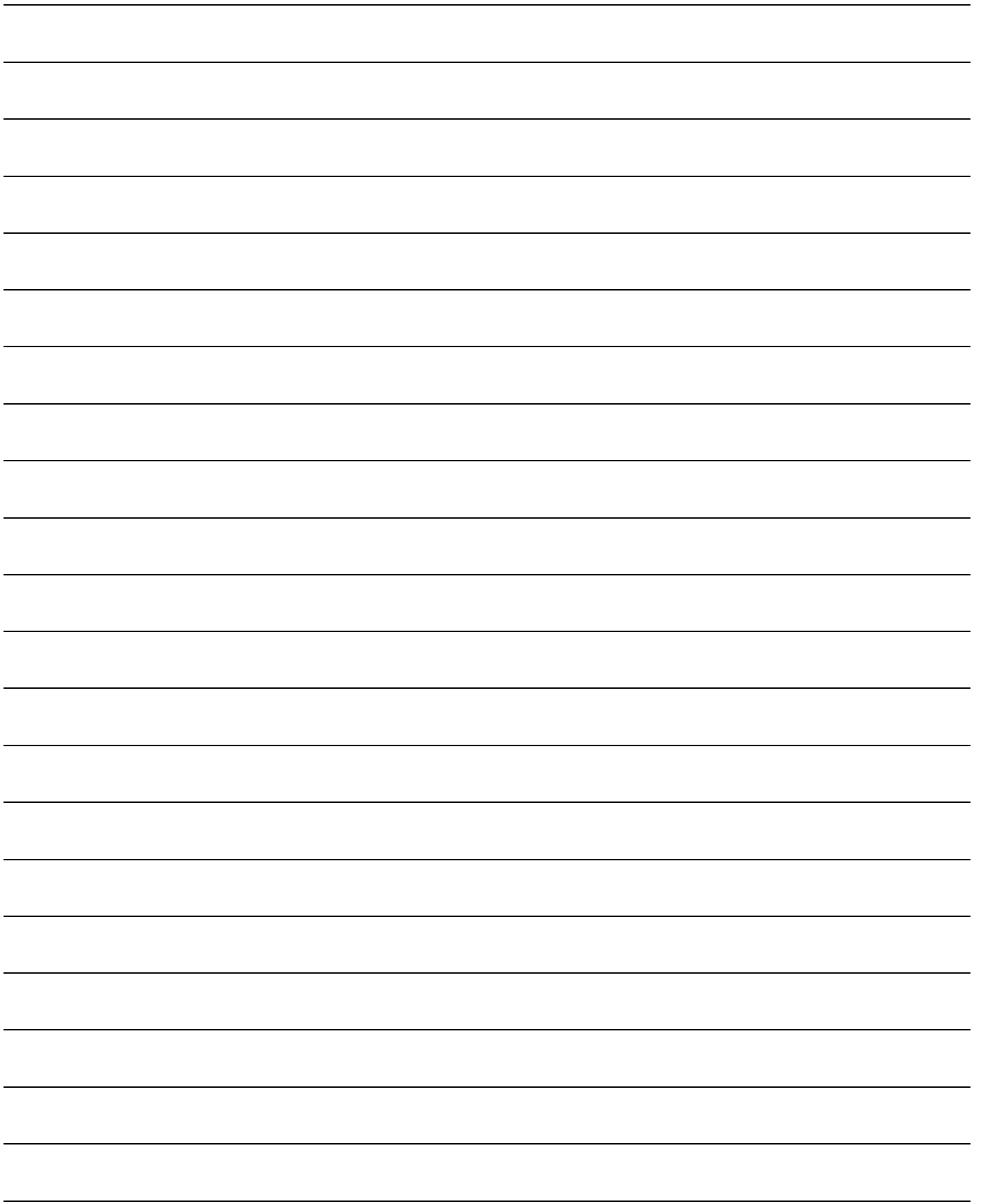
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> SEXUAL INFO <input type="checkbox"/> BICYCLE SAFETY
<input type="checkbox"/> PEER PRESSURE <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION AFFECTION
<input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SMOKING, ALCOHOL, DRUGS <input type="checkbox"/> OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:



13 to 21 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) (First)		ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
-----	------------------------------	---	-----------------------------------	-----------------------------------

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
--------	--------	----------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> Hgb/Hct _____ (9 mo, adolescent females & as indicated)	<input type="checkbox"/> OTHER (specify, as indicated)
--	--

SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	RESULTS: RIGHT ____ LEFT ____ BOTH ____	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)	<input type="checkbox"/> REFERRED
---	---	--	-----------------------------------

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

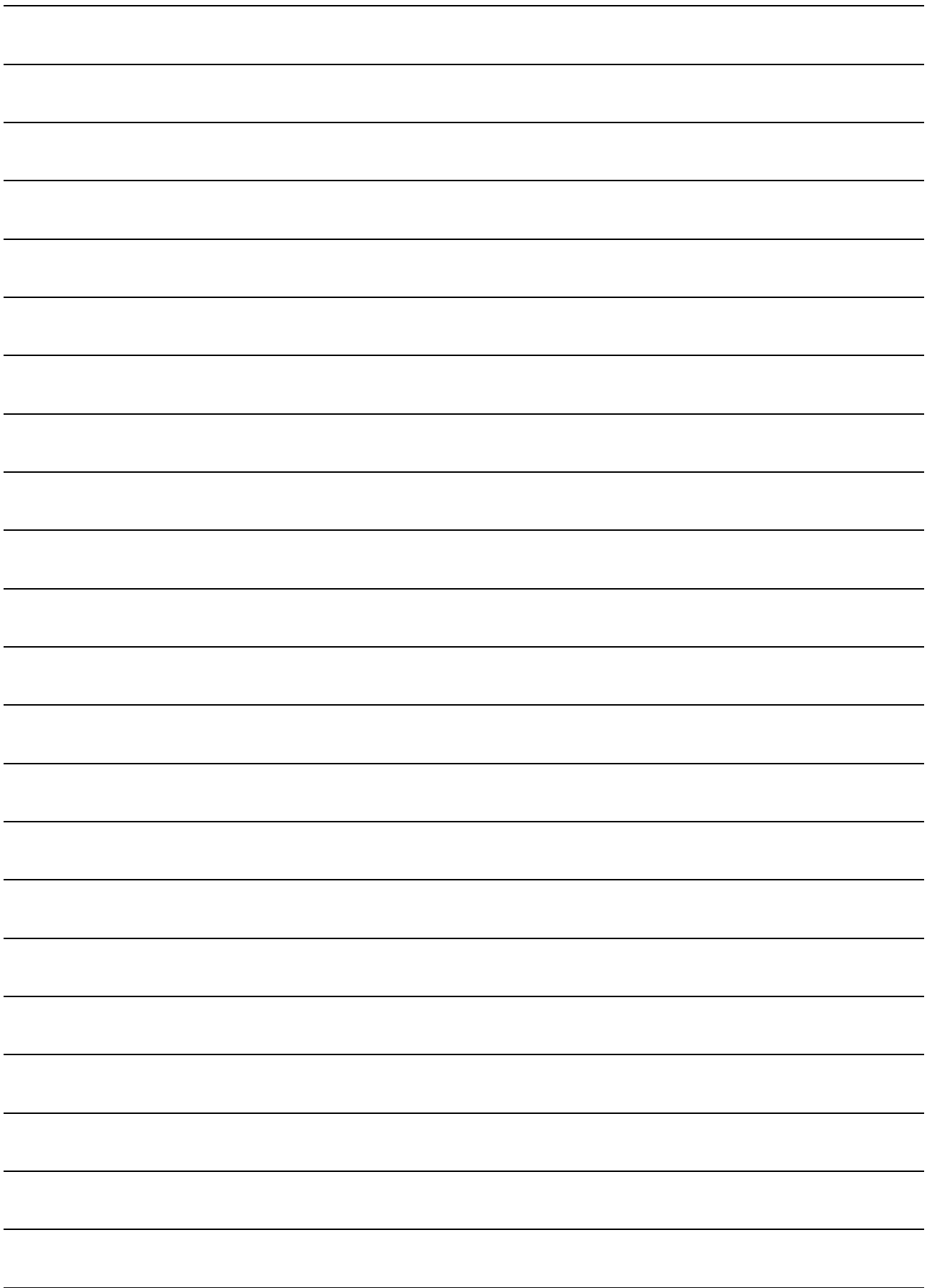
IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> CAR/SEAT BELT SAFETY	<input type="checkbox"/> SEXUAL ED & STDs	<input type="checkbox"/> PHYSICAL ACTIVITY
<input type="checkbox"/> PREGNANCY PREVENTION	<input type="checkbox"/> NUTRITION	<input type="checkbox"/> COMM. AFFECTION
<input type="checkbox"/> MOTORCYCLE/ HELMET SAFETY	<input type="checkbox"/> SMOKING, ALCOHOL, DRUGS	
<input type="checkbox"/> SCHOOL PERFORMANCE	<input type="checkbox"/> BREAST OR TESTICULAR SELF-EXAM	

DIAGNOSIS:
PLAN:
SIGNATURE:



APPENDIX C

CHILD HEALTH CHECK-UP

Initial Comprehensive Health
and Developmental History Form



Child Health Check-Up Initial Comprehensive Health and Developmental History Form

PLEASE PRINT

PERSONAL

NAME (Last) (First)		ID	DATE
DATE OF BIRTH	AGE	ACCOMPANIED BY	RELATIONSHIP

COMPREHENSIVE HEALTH AND DEVELOPMENTAL HISTORY (including physical and behavioral health development)

ALLERGIES	None
CURRENT AND RELEVANT PAST MEDICATIONS	None
RELEVANT GROWTH AND DEVELOPMENT STATUS	WNL
MENTAL HEALTH STATUS*	Normal for age
SIGNIFICANT ILLNESSES	None
HOSPITALIZATIONS AND SURGERIES	None
RELEVANT FAMILY HISTORY	None

* Providers based on medical discretion may use the Behavioral Health & Developmental Screening Form to determine the child's behavioral health status. If the child has a positive response to any of the questions on the tool, the child should be referred for further evaluation. See Appendix E in the Child Health Check-Up Coverage and Limitations Handbook for the Behavioral Health & Developmental Screening Form. Providers may photocopy this tool for their use.

APPENDIX D

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Recommendations for Preventive Pediatric Health Care (RE9535)

Committee on Practice and Ambulatory Medicine

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care**.

AGE ⁵	INFANCY ⁴										EARLY CHILDHOOD ⁴						MIDDLE CHILDHOOD ⁴						ADOLESCENCE ⁴						
	PRENATAL ¹	NEWBORN ²	2-4d ³	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
HISTORY Initial/Interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS Height and Weight Head Circumference Blood Pressure	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING Vision Hearing	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT⁸	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION⁹	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-GENERAL¹⁰ Hereditary/Metabolic Screening ¹¹ Immunization ¹² Hematocrit or Hemoglobin ¹³ Urinalysis	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES-PATIENTS AT RISK Lead Screening ¹⁶ Tuberculin Test ¹⁷ Cholesterol Screening ¹⁸ STD Screening ¹⁹ Pelvic Exam ²⁰	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
ANTICIPATORY GUIDANCE²¹ Injury Prevention ²² Violence Prevention ²³ Sleep Positioning Counseling ²⁴ Nutrition Counseling ²⁵	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
DENTAL REFERRAL²⁶	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

- A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
- Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged and instruction and support offered. Every breastfeeding infant should have an evaluation 48-72 hours after discharge from the hospital to include weight, formal breastfeeding evaluation, encouragement, and instruction as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
- For newborns discharged in less than 48 hours after delivery per AAP statement "Hospital Stay for Healthy Term Newborns" (1995).
- Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
- If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- If the patient is uncooperative, rescreen within 6 months.
- All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing statement, "Newborn and Infant Hearing Loss: Detection and Intervention" (1999).
- By history and appropriate physical examination: if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
- These may be modified, depending upon entry point into schedule and individual need.
- Metabolic screening (eg, thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
- Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunizations.
- See AAP *Pediatric Nutrition Handbook* (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (eg, premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States. *MMWR*, 1998;47(RR-3):1-29.
- All menstruating adolescents should be screened annually.
- Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
- For children at risk of lead exposure consult the AAP statement "Screening for Elevated Blood Levels" (1998). Additionally, screening should be done in accordance with state law where applicable.
- TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done upon recognition of high-risk factors.
- Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
- All sexually active patients should be screened for sexually transmitted diseases (STDs).
- All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.
- Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP *Guidelines for Health Supervision III* (1998).
- From birth to age 12, refer to the AAP injury prevention program (TIPP[®]) as described in *A Guide to Safety Counseling in Office Practice* (1994).
- Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level" (1999).
- Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Positioning and Sudden Infant Death Syndrome (SIDS): Update" (1996).
- Age-appropriate nutrition counseling should be an integral part of each visit per the AAP *Handbook of Nutrition* (1998).
- Earlier initial dental examinations may be appropriate for some children. Subsequent examinations as prescribed by dentist.

Key:
 • = to be performed
 S = subjective, by history
 O = objective, by a standard testing method
 ←•→ = the range during which a service may be provided, with the dot indicating the preferred age.

NB: Special chemical, immunologic, and endocrine testing is usually carried out upon specific indications. Testing other than newborn (eg, inborn errors of metabolism, sickle disease, etc) is discretionary with the physician.
 The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright ©1999 by the American Academy of Pediatrics. No part of this statement may be reproduced in any form or by any means without prior written permission from the American Academy of Pediatrics except for one copy for personal use.



APPENDIX E

BEHAVIORAL HEALTH AND DEVELOPMENTAL SCREENING FORM

BEHAVIORAL HEALTH and DEVELOPMENTAL SCREENING FORM

CHILD'S NAME: _____		
(LAST)	(FIRST)	(MIDDLE)
MEDICAID ID #: _____	SEX: M: _____ F: _____	DATE OF BIRTH: ____/____/____

SECTION A: BEHAVIORAL HEALTH RISK FACTORS: (Please refer to the attached *SCREENING FORM GUIDELINES* for an expanded discussion of risk factors. Your own professional judgment will determine whether you should refer for a behavioral health assessment based on the presence of one or more indicators. In all instances, however, when you believe any of the following three factors is present, you should refer for an assessment.)

- Child's history includes incident(s) of severe neglect or physical, emotional, sexual abuse or family violence.
- Child's behavioral history includes incident(s) of self-destructive or aggressively violent behavior.
- Family history includes severe emotional, behavioral, or neurological disorder or severe mental illness.

SECTION B: BEHAVIORAL HEALTH SCREENING:

Behavioral Indicators	Yes	No	Behavioral Indicators	Yes	No
1. Excessively fearful, anxious, sad, withdrawn			11. Aggression or threats to people or animals		
2. Difficulties in sleeping or feeding/eating routines			12. Talks about hurting self or hurts self		
3. Shows little range of age-appropriate emotions			13. Drop in grades, school performance, or attendance		
4. Easily distressed/distracted by environment			14. Use of alcohol or other drugs		
5. Defiant, often active refusal to comply			15. Hallucinations, delusions or other unusual behaviors or problems		
6. Decreases in play or regression in development			16. Emotional or behavioral problems in school or with peers		
7. Age-inappropriate sexual activity			17. Parents/household members abuse alcohol and/or prescription drugs, or use illegal drugs		
8. Impulsive, distractible, forgetful			18. Parent shows little attention, interest or engagement with the child		
9. Destruction of property			19. Parent shows signs of emotional/mental health difficulties		
10. Serious rule breaking			20. Parent-child relationship or communication appears troubled		

SECTION C: DEVELOPMENTAL SERVICES SCREENING:

To be answered by medical professional administering screening:	Yes	No	To be asked of the parent/guardian:	Yes	No
1. Does the screening reveal the existence of delayed development, mental retardation, cerebral palsy, spina bifida, autism or Prader Willi Syndrome?			5. Does your infant/child seem socially withdrawn or have difficulty communicating?		
2. Does the screening reveal the child is at risk of a later diagnosis of cerebral palsy, mental retardation, autism or Prader Willi Syndrome?			6. Is your infant/child extremely resistant to change in daily routine or sleeps less than 5 hours/ night?		
3. Is there evidence that the primary caregiver has a developmental disability?			7. Is your child in special education classes in school?		
4. Are you or your child's physician concerned about your child's development?			8. Does your child receive SSI because of a developmental disability?		

NOTE: If "yes" to questions 1-8 above, refer the child to Children's Medical Services ages birth to 3, to Developmental Services if greater than 3 years old.

<p>OUTCOME OF SCREENING:</p> <p><input type="checkbox"/> No referral is needed</p> <p><input type="checkbox"/> Referral is needed, and parent/guardian consents</p> <p><input type="checkbox"/> Referral is needed, but parent/guardian declines</p> <p>Referral made for:</p> <p><input type="checkbox"/> Mental Health Assessment</p> <p><input type="checkbox"/> Substance Abuse Assessment</p> <p><input type="checkbox"/> Children's Medical Services Assessment (0-3)</p> <p><input type="checkbox"/> Developmental Services Assessment (3-21)</p> <p><input type="checkbox"/> Functional Behavioral Assessment</p> <p>(Signature/title of screener) _____ (Date of screening) _____</p>	<p>REFERRAL FOR ASSESSMENT:</p> <p><input type="checkbox"/> Referral made on: ____/____/____</p> <p><input type="checkbox"/> Referral made to: _____</p> <p style="text-align: center;">(Agency name)</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Agency address)</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Agency phone number)</p> <p>(Signature/title of person referring) _____ (Date) _____</p>
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SCREENING FORM GUIDELINES

PURPOSE: To identify children needing referral for a behavioral health or developmental assessment.

DISCUSSION OF RISK FACTORS AND SCREENING QUESTIONS: The risk factors and screening questions are not all-inclusive and are intended only as indicators of a possible problem that may need further assessment. The screening tool is intended to augment your own professional judgment.

SECTION A: Behavioral Health Risk Factors

The risk factors discussed here are to assist in determining whether you should refer the child you are screening for an assessment by a behavioral health professional. Any combination of factors or one factor alone, such as an incident of sexual abuse, may be sufficient to prompt a referral. Your own professional judgment and knowledge of normal child development, the cultural context of the family, and the individual child being screened should determine whether you refer for an assessment.

The literature points to a number of factors in a child's life that could place him or her at high risk of serious emotional disturbance or substance abuse. A child having any one of the following three major risk factors would be appropriate for referral for an assessment:¹

1. The child's history includes incident(s) of being neglected or of being physically, sexually, or emotionally abused.
2. The child's behavioral history includes incident(s) of any one of the following: a) suicidal ideation or attempt, or any other self-destructive or intentionally self-harmful behavior; b) violent aggression or hostility; c) delusions or hallucinations; d) substance abuse; or e) intentionally delinquent activity.
3. The custodial or biological parent's behavioral history includes incidents of any one of the following: a) suicidal ideation or attempt or any other self-destructive behavior; b) violent aggression or hostility; c) serious psychiatric illness; d) substance abuse/dependence; or e) intentional criminal activity.

Other factors² that can place children at risk for mental and behavioral disorders include:

- Genetic factors that increase a child's vulnerability to autism, affective and anxiety disorders, Tourette's disorder, and attentional and learning disorders.
- Biological "insults," such as physical trauma or exposure to toxic chemicals or drugs.
- Poor prenatal care, which leads to increased risk of premature birth and a host of related problems.
- Chronic physical illness, such as leukemia, diabetes mellitus, asthma, cystic fibrosis, epilepsy, and AIDS.
- Cognitive impairments, such as those resulting from mental retardation, as well as deficits in sensory perception, including deafness and blindness.
- Persistent psychological adversity, such as poverty, disorganized and inadequate schooling, and homelessness.
- Domestic violence.
- Parental mental illness, with the potentially dangerous combination of psychologically traumatic disruptions of family life and inconsistent parenting.
- A history of significant loss(es).

The following section provides a context for asking the child and the parent or guardian questions about indicators of serious emotional disturbance or substance abuse.

¹ M. Oldknow and E. Dickinson, *New Mexico Department of Children, Youth and Families*

² "National Plan for Research on Child and Adolescent Mental Disorders," U.S. Department of Health and Human Services, Alcohol, Drug Abuse and Mental Health Administration

SECTION B: Behavioral Health Screening Indicators

Section B: Behavioral Health Screening Indicators

- 1. Excessively fearful, anxious, sad, withdrawn.** *Discussion:* Infants and young children may appear sad, lethargic, show a lack of interest in or failure to explore the environment, appear unusually wary and fearful or show panic. Older children may demonstrate the above plus show specific fears, talk about feeling unloved or hopeless and lack self confidence. These behaviors indicate the need for further assessment.
- 2. Difficulties in sleeping or feeding/eating routines.** *Discussion:* Infants and young children may have persistent difficulties in falling or staying asleep, refuse to eat, eat too much or too little. In addition to the above difficulties, older children may also hoard or steal food, engage in bingeing or purging or sleep excessively. Abrupt changes in sleeping or eating patterns or persistently abnormal patterns of sleeping or eating can be signs of serious emotional disturbance.
- 3. Shows little range of age-appropriate emotions.** *Discussion:* Infants and young children may not demonstrate typical facial or vocal expressions of pleasure, contentment, anger or pain or show persistent negative mood without signs of positive mood; gaze avert or resist positive social stimulation. Older children may also appear unusually guarded in social interaction. When age appropriate affect is absent, further evaluation is indicated.
- 4. Easily distressed/disrupted by environment.** *Discussion:* Infants and young children may show unusual distress and strong negative responses to typical environmental stimuli such as sound, touch and sights; resist holding or arch when held and be difficult to console. They may also be easily over-stimulated; find novelty or change distressful; be unable to calm or comfort themselves or be “too clingy.” Older children may have difficulty with transitions or change and be especially slow to recover after distress. These behaviors are indicative of regulatory problems which should be assessed.
- 5. Defiant, often active refusal to comply.** *Discussion:* Children who are excessively demanding and irritable, routinely do not comply or cooperate with requests that are clearly understood (often with negative emotion), persistently resist limits, purposely annoy, argue and blame others are in need of further evaluation for underlying mental health problems.
- 6. Decrease in play or regression in development.** *Discussion:* Declines in play may be evidenced by a reduction in the amount of play, play that is repetitive or play that is less emotionally positive. A child may also demonstrate a loss of previously mastered skills. Regression in play or developmental skills warrants further assessment.
- 7. Age-inappropriate sexual activity.** *Discussion:* Younger children may display indiscriminant affection toward unfamiliar adults, engage in precocious sexual play, appear preoccupied with sexual activities and themes and demonstrate age-inappropriate knowledge of sexual activity. Older children may dress or behave in sexually provocative ways and engage in sexual activity beyond what is expected for their age. These behaviors could indicate child sexual abuse and should receive further evaluation.
- 8. Impulsive, distractible, forgetful.** *Discussion:* A young child who has an activity level that is very high and disorganized, doesn't seem to listen, talks excessively, interrupts others and has difficulty keeping his hands to himself should be referred for assessment and possible intervention in preparation for entry into school. In addition to these behaviors, older children may also be very unorganized, fail to follow through on tasks such as chores or homework and have difficulty concentrating in school.
- 9. Destruction of property.** *Discussion:* Children who deliberately destroy their own or others toys, clothing, or property; set fires to cause damage should be evaluated for underlying mental health problems.
- 10. Serious rule-breaking.** *Discussion:* Children who demonstrate a persistent pattern of violating age-appropriate norms and rules, e.g., truancy, running away, shoplifting and theft should be referred for a mental health assessment.
- 11. Aggression or threats to people or animals.** *Discussion:* A young child may be involved in chronic fighting, persistent physical aggression, display intentional cruelty to animals, bully or verbally threaten others, seem preoccupied with violence, cruelty or fire or seriously injure someone. In addition to the above behaviors, an older child may force sexual activity on others or use weapons to hurt or threaten. “Normal” youngsters may tease, threaten or shove other children, but deliberate cruelty or physically hurting others or animals usually is indicative of a serious problem.

12. **Talks about hurting self or hurts self.** *Discussion:* Young children are not immune to suicidal behavior and teenagers sometimes react to seemingly minor situations or trivial incidents with suicidal behavior. Be very concerned about children who report engaging in unsafe or dangerous actions/activities, express feelings of worthlessness, make statements such as “I might as well be dead” or show indications of previous self-inflicted injury or mutilation. Children who know about the suicide of a parent, sibling, friend or other close person, including celebrities, are at particular risk. **Listen carefully for any warning signals of possible suicidal intent, and refer for immediate evaluation.**
13. **Drop in grades, school performance or attendance.** *Discussion:* A pattern of change in school performance or attendance may signify other problems such as depression or substance abuse and should be evaluated further.
14. **Use of alcohol or drugs.** *Discussion:* It is important to ask specific questions that address use of alcohol, tobacco, drugs (illegal or prescription) and related risk taking activities. A child who is drinking alcohol or taking non-prescribed drugs should be referred for a substance abuse assessment, especially if the child’s use is causing problems in a major area of his life such as health, family, legal, school or employment. **If the child is younger than 11, any substance use should trigger a referral.**
15. **Hallucinations, delusions, or other unusual behaviors or problems.** *Discussion:* A child who demonstrates a marked impairment in social interaction (little eye contact or social responsivity); persistent and repetitive body movements such as hand-waving or head banging; no change in tone of voice; persistent preoccupation with an object; set routine or interest; involuntarily makes noises; or reports hearing voices or seeing things that are not there is in need of a mental health assessment.
16. **Emotional or behavioral problems in school or with peers.** *Discussion:* Any of the problems described above cause problems which would interfere with progress in school and/or relationships with teachers or peers (e.g., difficulties in child care settings, poor achievement, rejection by peers, social isolation). The child’s problems may not clearly match any of those described in the questions above, and yet the parent or guardian feels that there is something wrong, something that needs attention. In this situation, a referral for further assessment should be considered.
17. **Parents/household members abuse alcohol and/or prescription drugs, or use illegal drugs.** *Discussion:* If family members are abusing alcohol and/or drugs or using illegal drugs, the child may already have or be at risk for developing a substance abuse problem.
18. **Parent shows little attention, interest, or engagement with the child.** *Discussion:* This pattern may reflect parental problems with depression or substance abuse.
19. **Parent shows signs of emotional/mental health difficulties.** *Discussion:* Mental health problems in parents are a risk factor for mental health problems in their children due to the increased genetic risk or due to impaired parenting resulting from the parental disorder.
20. **Parent-child relationship or communication appears troubled.** *Discussion:* Interactions between the parent and child may demonstrate a poor fit, where the parent is not reading the child’s cues appropriately, which may lead to anger and harsh or inappropriate discipline.

SECTION C: Developmental Services Screening

To be answered by the Medical Professional administering the Screening Form:

1. **Does the screening reveal the existence of delayed development or mental retardation, cerebral palsy, spina bifida, autism, or Prader Willi Syndrome?** *Discussion:* Under Florida law (Chapter 393, Florida Statutes), a diagnosis of mental retardation, cerebral palsy, autism, spina bifida, or Prader Willi Syndrome is sufficient to indicate that a child has a developmental disability. Children ages birth to three years old should be referred to Children’s Medical Services. Children greater than three years old and adults with developmental disabilities should be referred to Developmental Services.
2. **Does the screening reveal the child is at risk of a later diagnosis of cerebral palsy, mental retardation, autism, or Prader Willi Syndrome?** *Discussion:* A child under five years of age who is demonstrating delayed development, particularly in the areas of cognitive, language or physical development, may be at greater than normal risk of a later diagnosis of developmental disability, including cerebral palsy, mental retardation, autism, or Prader Willi Syndrome if s/he:
 - is demonstrating delayed development, particularly in the areas of cognitive, language or physical development; or

- has a congenital disorder, illness, or other medical or physical condition such as: Down Syndrome, microcephaly, hydrocephaly, cytomegalovirus infection, Fetal Alcohol Syndrome, a metabolic or endocrine disorder, or severe encephalopathy resulting from injury to the brain due to trauma, drowning, poisoning or infection. Such children should be referred to Children’s Medical Services, if birth to three years old, or Developmental Services, if older than three.
3. **Is there evidence that the primary caregiver has a developmental disability?** *Discussion:* A child under five years old whose parent(s) or primary caregiver has a diagnosed developmental disability may be eligible for services from Developmental Services if the parent(s) or caregiver requires assistance in meeting the needs of the child. Under Florida law (Chapter 393, Florida Statutes), a diagnosis of mental retardation, cerebral palsy, autism, spina bifida, or Prader Willi Syndrome constitutes a developmental disability.
 4. **Are you or your child’s physician concerned about your child’s development?** *Discussion:* A child who is not demonstrating appropriate developmental milestones for her/his age range should be referred to Children’s Medical Services or Developmental Services, according to the child’s age.

To be asked of the parent/guardian:

5. **Does your infant/child seem socially withdrawn or have difficulty communicating?** *Discussion:* If the child acts as if s/he is in her/his “own little world” for long periods of time, s/he should be referred to Children’s Medical Services if ages birth to three years old and to Developmental Services if older than three.
6. **Is your infant/child extremely resistant to change in daily routine? Does s/he frequently sleep less than five hours per night?** *Discussion:* Extreme resistance to change in daily routine is one symptom of autism. Other symptoms include resistance to social interaction, delayed language development, and repetitive behaviors, such as hand-flapping, rocking, or head-banging, repeatedly “parroting” words or phrases s/he has just heard, and reacting strongly or violently to being touched, hugged, or cuddled.
7. **Is your child in special education classes in school?** *Discussion:* Some children receive services through the public school system and are in special education classes, such as educable mentally handicapped (EMH), trainable mentally handicapped (TMH), profoundly mentally handicapped (PMH), or physically impaired. If there is a need for services not being provided by the public school system that may be provided by Children’s Medical Services or Developmental Services, the child should be referred. This should be discussed with the family to determine if additional services are needed. Services may include family support services, such as respite, parent training, equipment, and other non-educational services.
8. **Does your child receive SSI because of a developmental disability?** *Discussion:* A child who is a current recipient of SSI because of a developmental disability should be referred to Children’s Medical Services or Developmental Services, according to the child’s age.

APPENDIX F

LEAD POISONING RISK ASSESSMENT



LEAD POISONING RISK ASSESSMENT

	DATE				
Does your child live in or regularly visit (once a week or more) any house or building built before 1978?					
Does your child live in or regularly visit any house or building that has vinyl mini-blinds, lead pipes, pipes with lead solder joints, or had metal pipes replaced or repaired within the last five years?					
Does your child have a mother, sibling or playmate who has or did have lead poisoning?					
Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? Some examples are employment in building renovation, an auto battery factory, auto or radiator repair shop, highway bridge sandblasting or painting, welding metal structures, wire cable cutting or hobbies such as refinishing furniture, casting bullets, making stained glass, toy soldiers, dive weights, or fishing weights?					
Does your child eat food that had been stored in metal cans, from leaded crystal, ceramic, or pewter dishes, or have contact with cosmetics, candies, spices, and home or folk remedies not made or sold in the United States? Have you ever seen your child eat dirt or paint chips?					
Does your child play in loose soil, near a busy road or near any industrial sites such as battery recycling plant, junk yard or lead smelter?					
Has your child lived in a foster care home or in a country other than the United States?					
<p>Place date at the top of the column. Indicate response by “Y” for yes, “N” for no, or “U” for unknown in the appropriate blocks. Sign name and title at the bottom of appropriate column.</p> <p>A yes or unknown response to any question indicates the child is at risk for lead poisoning. The child should receive blood lead testing and appropriate follow-up. See Risk Assessment, Screening and Follow-up of Children for Elevated Blood Lead Levels.</p>	Signature/Title	Signature/Title	Signature/Title	Signature/Title	Signature/Title

Name:
ID No:
Date of Birth:

APPENDIX G

CHILD HEALTH CHECK-UP AUDIT TOOL

Child Health Check-Up Audit Tool for All Provider Types

The following *required* components must be assessed and documented in the child's medical record.

REQUIRED COMPONENTS	DOCUMENTED	NOT DOCUMENTED
Comprehensive Health and Developmental History consisting of:		
Past Medical History		
Developmental History		
Behavioral Health Status		
Nutritional Assessment		
Developmental Assessment		
Comprehensive Unclothed Physical Examination		
Dental Screening		
Including dental referral, when required		
Laboratory Tests		
Including blood lead testing, when required		
Sensory Screenings		
Vision Screening		
Including objective vision testing, when required		
Hearing Screening		
Including objective hearing testing, when required		
Appropriate Immunizations		
Health Education, Anticipatory Guidance		
Diagnosis and Treatment		
Referral and Follow-Up, as appropriate		

If a component was provided within 90 days before the Child Health Check-Up and the results were documented, the provider does not need to repeat the component. An exception should be made if the recipient's environment or medical condition indicates that the component should be repeated. Or if, based on medical discretion, a component has not been performed within approximately 90 days, but within reasonable time based on the recipient's age and with documentation of medically appropriate rationale, i.e., 2 year old participates in the Early Intervention program.



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