**Name of Child:** Click to dd text here

**Name of Biometrics Volunteer:** Click to add text here

**BIOMETRICS**

|  |  |  |  |
| --- | --- | --- | --- |
| WHO/ CDC growth chart Downs Syndrome growth chart Other growth chart used, specify | | | |
|  | | | % for age |
| Weight\*\* | kg | lb | % |
| Height\*\*  Unable to obtain | cm | in | % |
| Body Mass Index (BMI) |  | | % |
| Head Circumference | cm | in | % |

**VACCINE RECORDS**

*Kindly review the child’s vaccination card as provided by the parent*

|  |  |
| --- | --- |
| Is the child up to date on CDC/WHO recommended childhood vaccines? | Yes  No |
| If not, please indicate the missed vaccines below | |

**VITAL SIGNS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Temperature (degree F) | Normal  Elevated | | | | |
| Pulse | Beats per minute | | Normal  Elevated | | Low |
| Systolic Blood Pressure  Right Arm  Leg | mmHg | %ile | Normal | Elevated | Low |
| Diastolic Blood Pressure  Right Arm  Leg | mmHg | %ile | Normal | Elevated | Low |
| Pulse-Oximetry | % | | Normal | | Low |

**AUDIO & VISUAL SCREENS**

Visual Acuity

* + Lea Symbols chart. Left     /     Right     /
  + Instrument-based vision screen: PlusOptix vision  GoCheck Kids
  + Autorefractor
  + Fundus camera

Otoacoustic Emissions Result Left      Right

**Name of Child:** Click to add text here

**Name of Developmental Screening Volunteer:** Click to add text here

**DEVELOPMENTAL SCREENING**

***Social-Emotional Area***

Social-emotional skills are important for connecting with others. They help the child to manage their emotions, build healthy relationships and to behave in a socially acceptable manner.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Global question (surveillance)*** | ***Never (not yet)*** | ***Rarely OR with Significant support*** | ***Sometimes OR with Minimal support*** | ***Always OR Independently*** |  |
| Does your child play with other children/have an interest in making new friends when there is an opportunity? |  |  |  |  | For progression determination only |
| ***Specific questions (screening)*** | | | | | |
| 1. Does your child smile back at family members and familiar others when they smile? |  |  |  |  | *06-months* |
| 1. Does your child show appropriate fear when with strangers? |  |  |  |  | *09-months* |
| 1. Does your child explore new environments and objects if you or other family members are close by? |  |  |  |  | *18-months* |
| 1. Does your child imitate/mimic behaviors that you and others do? |  |  |  |  | *2-years* |
| 1. Does your child show that they enjoy being with close friends and family members? |  |  |  |  | *3-years* |
| 1. Does your child play cooperatively with others (e.g., interacting with other children in a friendly way)? |  |  |  |  | *3-4 years* |
| 1. Does your child show an understanding that others have different thoughts and feelings than they do? |  |  |  |  | *5-years* |
| 1. Does your child tell you verbally or non-verbally when they are feeling sad, happy, or angry? |  |  |  |  | *6-years* |
| 1. Does your child become upset/ have tantrums easily? |  |  |  |  | *6-7 years* |

***Language & Communication Area***

Language is a set of sounds, words, gestures, etc. that have meaning. Communication involves people understanding information that is directed toward them and being able to share information with others through sounds, words, gestures, etc.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Global question (surveillance)*** | ***Never (not yet)*** | ***Rarely OR with Significant support*** | ***Sometimes OR with Minimal support*** | ***Always OR Independently*** |  |
| Is your child able to communicate with others using words, signs, or assistive devices? |  |  |  |  | For progression determination only |
| ***Specific questions (screening)*** | | | | | |
| 1. Does your child imitate sounds and gestures (e.g., wave, clap, point) made by other people? |  |  |  |  | *9-months* |
| 1. Does your child vocalize (i.e., make sounds that change in tone add “as if they are talking”) or make different gestures? |  |  |  |  | *12-months* |
| 1. Does your child respond verbally or non-verbally to requests (e.g., stopping behavior when asked, coming when called)? |  |  |  |  | *2-years* |
| 1. Does your child communicate by speaking, signing, or using assistive communicate in a way that others who know them well (e.g., family members) understand most of the time? |  |  |  |  | 3-years |
| 1. Does your child carry on a conversation using 2 to 3 sentences? |  |  |  |  | 4-years |
| 1. Does your child communicate (speak, sign, use a device) with people beyond family members (e.g., teachers, shopkeepers) in a way they can understand most of the time? |  |  |  |  | *5-6 years* |
| 1. Does your child read easy (i.e., written at age level) books? |  |  |  |  | *7 years* |
| 1. Does your child express themselves in writing (e.g. sharing ideas, feelings, experiences)? |  |  |  |  | *7-8 years* |

**Thinking, Reasoning and Problem-Solving Area**

Children are natural problem solvers. They use their thinking and reasoning skills to better understand it. Initially, they do this on a trial-and-error basis. As a child develops and becomes a more experienced problem-solver, they use past experiences to help them solve new problems.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Global question (surveillance)*** | ***Never (not yet)*** | ***Rarely OR with Significant support*** | ***Sometimes OR with Minimal support*** | ***Always OR Independently*** |  |
| Does your child explore their environment (toys, books, textures, etc.)?  Does your child show the ability to use what they have learned in their daily life? |  |  |  |  | For progression determination only |
| ***Specific questions (screening)*** | | | | | |
| 1. Does your child try to get things that are within reach? |  |  |  |  | *6-9-months* |
| 1. Does your child try to use objects after you show them how (e.g., using a cloth to dry hand)? |  |  |  |  | *9-12-months* |
| 1. Does your child point to at least one body part correctly when asked? |  |  |  |  | *18-months* |
| 1. Does your child point to the correct items in a picture book when asked? |  |  |  |  | *2-years* |
| 1. Does your child explore how things work (i.e., by trying them out)? |  |  |  |  | *2-years* |
| 1. Does your child avoid common dangers at home (steep stairs, hot stoves, etc.)? |  |  |  |  | *2-3 years* |
| 1. Does your child show an understanding of the difference between something real and make-believe? |  |  |  |  | *5-6 years* |
| 1. Does your child follow a multi-step daily routine (e.g., get ready for school – eat breakfast, brush teeth, get dressed, etc.)? |  |  |  |  | *6-7 years* |
| 1. Does your child avoid common dangers in the community (e.g., stopping at a red light, looks both ways when crossing the street)? |  |  |  |  | *7 years* |

***Fine Motor Area***

Motor development refers to the growth and strengthening of a child’s bones, muscles and ability to interact with their surroundings. Fine motor skills refer to small movements of hands, feet, fingers, toes etc.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Global question (surveillance)*** | ***Never (not yet)*** | ***Rarely OR with Significant support*** | ***Sometimes OR with Minimal support*** | ***Always OR Independently*** |  |
| Does your child use small objects for their intended purpose? |  |  |  |  | For progression determination only |
| ***Specific questions (screening)*** | | | | | |
| 1. Does your child feed themselves small pieces of food using their hands? |  |  |  |  | *9-12 months* |
| 1. Does your child drink from a cup or a glass? |  |  |  |  | *12-18 months* |
| 1. Does your child build a tower of 2 blocks or place one object on top of the other? |  |  |  |  | *12-18 months* |
| 1. Does your child scribble with a crayon or other writing object? |  |  |  |  | *18 months* |
| 1. Does your child put on at least 1 piece of clothing correctly (e.g., t-shirt on torso rather than on leg)? |  |  |  |  | *2 years* |
| 1. Does your child feed themselves using a spoon/fork or other utensils? |  |  |  |  | *2-3 years* |
| 1. Does your child dress themselves putting on at least 2 pieces of clothing (e.g., t-shirt, shoes)? |  |  |  |  | *5-6 years* |
| 1. Does your child form letters of the alphabet correctly? |  |  |  |  | *6-7-years* |
| 1. Is your child’s printing/writing legible or are they able to use an assistive device instead of printing (e.g., tablet, smart phone) effectively? |  |  |  |  | *7-8 years* |

***Gross Motor Area***

Gross motor skills involve the development of large muscles that enable children to sit, crawl, walk, run, jump, pull themselves up, push themselves, etc.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Global question (surveillance)*** | ***Never (not yet)*** | ***Rarely OR with Significant support*** | ***Sometimes OR with Minimal support*** | ***Always OR Independently*** |  |
| Does your child move toward objects or people as needed or desired?  Is your child becoming stronger and more coordinated in physical activity? |  |  |  |  | For progression determination only |
| ***Specific questions (screening)*** | | | | | |
| 1. Does your child sit without support? |  |  |  |  | *6 months* |
| 1. Does your child walk independently across a room? |  |  |  |  | *15 months* |
| 1. Does your child walk up and down stairs (2 feet at a time) while holding onto a person or railing? |  |  |  |  | *18 months* |
| 1. Does your child run without falling? |  |  |  |  | *2.5 years* |
| 1. Does your child walk up steps, alternating feet? |  |  |  |  | *3 years* |
| 1. Does your child throw an object in the general direction they want? |  |  |  |  | *3 years* |
| 1. Does your child catch an object e.g. a small ball thrown to them with his/her hands? |  |  |  |  | *5-7-years* |
| 1. Does your child jump rope or jump over other obstacles? |  |  |  |  | *7-8 years* |

**Name of Child:** Click to add text here

**Name of Review of Systems, Targeted Surveillance**

**and Physical Exam Volunteer:** Click to add text here

**REVIEW OF SYSTEMS & TARGETED SURVEILLANCE**

Please check *all that apply*, and add any pertinent details or comments:

|  |  |
| --- | --- |
| **System** | **Symptoms** |
| 1. **GENERAL/**   **CONSTITUTIONAL** | unplanned / unexpected weight gain (last 6 months)  unplanned / unexpected weight loss (last 6 months) |
| 1. **HEAD/ EYES/ EARS/ NOSE/ THROAT** | Moves up close or farther away to see  Eyes move in different directions or tilts head to see  Eyes jerk repetitively side to side or up and down.  Difficulty hearing |
| 1. **CARDIOVASCULAR/ PULMONARY** | Ever fainted or passed out with physical exertion, sudden/ loud noises  Ever had abnormal heart test  Wheezing, coughing or shortness of breath with colds, at night, or with exercise. |
| 1. **NEUROLOGIC** | Headaches that are worse when lying down or that awakens your child from sleep  Unexplained early morning vomiting  Unexplained repetitive movements, twitching, shaking, or “spells” (e.g. staring) concerning for seizures  Short/ sudden movements, twitches, utterances  Excessively trips, falls, bumps into things due to difficulties with balance and/or coordination |
| 1. **ENDOCRINE** | Excessive thirst and/or drinking fluids, excessive urination  If child has Down S: > 1 yr since last thyroid screen |

**NUTRITION & GASTROINTESTINAL**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| 1. Vomiting, Choking or coughing related to feeds |  |  |
| 1. Excessive appetite, eating constantly |  |  |
| 1. Loose or watery stools |  |  |
| 1. Hard, pellet-like, or rock-like stools |  |  |
| 1. Child’s diet restricted due to:   Excessively picky eating  Medical restriction, specify | | |

**DENTAL**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. How many times a day do you clean / help clean your child’s teeth? | | | |
| 1. How many cavities has your child had in the past? | | | |
| 13. Does your child fall asleep either nursing or bottle feeding? | Never | Sometimes | Often |

**SLEEP**

|  |
| --- |
| 14. What time does your child go to bed? |
| 15.Does your child have a fixed bedtime routine? |
| 16.Does your child go to bed easily? |
| 17.Does your child have loud breathing, snoring, or pauses in breathing during sleep? |
| 18.Does your child sleep through the night? |

**PHYSICAL EXAM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General Observations** | | | | | | | | | | | | |
| **Mental status/ Bx** | Playful  Calm | Alert  Lethargic | | | | Irritable  Hyperactive | | | | | | |
| **Child’s interaction with parents and examiner**  Insufficient opportunity to observe | Joint attention  Reciprocal communication  Calms with parent  Good eye contact  Little or no eye contact | | | | | No/ minimal joint attention  No/ minimal reciprocal communication  Difficulty calming with parent  Other concern | | | | | | |
| **Head Eyes Ears Nose Throat** | | | | | | | | | | | | |
| **Face (dysmorphology)**  Normal | Frontal bossing  Shortened palpebral fissures  Epicanthal folds  Hypertelorism | | | Flattened nasal bridge  Flat philtrum  Thin upper lip  Small mouth  Low-set ears | | | | | Bilateral or multiple preauricular pits  Other | | | |
| **Eyes**  **Right**  **Left**  Normal | Ptosis  Bluish or gray sclera  Iris spots/discoloration  Corneal spots/discoloration | | * Red reflex:   Normal   * + 1. Abnormal | | | | Asymmetric pupillary reactivity  Diminished or asymmetric extraocular movements  Abnormal horizontal nystagmus  Vertical nystagmus | | | | | |
| **Ears**  **Right**  **Left**  Normal | Hearing aid/ cochlear implant | | | | | Abnormal Tympanic Membrane  Air/fluid levels/effusion  Perforation | | | | | | |
| **Oropharynx and upper airway**  Normal | Pharyngeal Inflammation  Tonsils Grade 3-4 | | | | | Cleft palate +/- lip | | | | | | |
| **Dentition**  Normal | Erythematous, swollen gingiva  Gum bleeding  Teeth pitting or odd shape  Hypodontia for age  Malocclusion/ crowding | | | | | White/ chalky spots on teeth  Obvious caries  Detail | | | | | | |
| **Core/ Trunk** | | | | | | | | | | | | |
| **Heart &**  **Cardiovascular**  Normal | Abnormal systolic murmur  Location:  Grade:  Radiation: | | | | | Diastolic murmur  Single loud S2 | | | | | | |
| **Lungs & Upper Airway**  Normal | Wheeze  Rales  Rhonchi  Diminished air movement: detail | | | | | Stridor:  At rest  Only with agitation  Continuous | | | | | | |
| **Abdomen**  Normal | Hepatomegaly  Splenomegaly  Mass: Size       Location | | | | | | | | | | | |
| **Musculoskeletal Exam** | | | | | | | | | | | | |
| **Chest/ ribs**  Normal | Pectus excavatum  Pectus carinatum  Shield chest or widely spaced nipples | | | | | **Spine**  Normal | | | | | Lordosis  Kyphosis  Scoliosis | |
| **Upper extremities**  **Arms and hands**  **Shoulders, elbows, wrists** | **Right**  **Left**  Normal  Unable to assess | | | | | Limited range of motion:  Contracture  Joint hypermobility | | | | | | |
| **Lower extremities**  **Hips, legs,**  **knees, ankles, feet** | **Right**  **Left**  Normal  Unable to assess | Limited range of motion  Contracture  Joint hypermobility  Pain | | | | Genu valgus: severe or asymmetric  Genu varus: severe or asymmetric | | | | | | Metatarsus adductus  Pes Cavus  Vertical talus  Clubfoot |
| **Neuromotor Exam** | | | | | | | | | | | | |
| **Cranial nerves**  **VII, XI, XII** (other CN under eyes)  Normal | Asymmetric facial movements.  At rest.  Smile, crying  Asymmetric turn of head  Tongue deviation  Difficulty with palate elevation | | | | | | | | | | | |
| **Motor**  Normal |  | Right Upper Extremity | | | | Left Upper Extremity | | | | | | |
| Muscle bulk | Low | | | | Low | | | | | | |
| Muscle tone | Low  High | | | | Low  High | | | | | | |
| Strength | /5 | | | | /5 | | | | | | |
| Pronator Drift | Right upper extremity | | | | | | Left upper extremity | | | | |
| **Reflexes**  Normal | Biceps | Normal | | | | 0 | | | 1+ | | | 3+ |
| Patellar | Normal | | | | 0 | | | 1+ | | | 3+ |
| **Movement & Coordination** | Normal  Unable to assess | | | | Ataxia  Abnormal movements  (chorea, athetosis, dystonia) | | | | | Abnormal finger to nose test | | |
| **Dermatology** | | | | | | | | | | | | |
| **Skin**  Normal | Atypical bruising/ petechiae  Abrasions, ulcers, callouses, scars  Rash, macule, papule | | | | | Hyperpigmented lesions  Hypopigmented lesions | | | | | | |
| **Nails**  Normal | Clubbing  Pale & spoon-shaped | | | | | | | | | | | |
| **Hair**  Normal | Patchy hair loss with broken hairs  Thinning hair or hair loss with smooth scalp | | | | | | | | | | | |

**Additional exam details (free text)\_**

**IMPRESSIONS, ASSESSMENT & PLAN**

**Name of Child:** Click to add text here

**Name of Impressions, Assessment, & Plan Volunteer:** Click to add text here

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Needs/ Concerns/ Suspected Health Conditions**  **(check all that apply)** | **Recommendations: Action Plan** | | | |
| **Education/ Resources/ Counseling** | | **Referrals**  **Emergent**  **Urgent**  **Routine** | |
| **GENERAL HEALTH SUPERVISION** | | | | |
| General health supervision/ preventive care  Dental preventive care  Under-vaccination | General health supervision needs  Specific health condition requiring specialty health supervision  Vaccines | | Medical home  Dental home  Vision screen  Hearing screen | |
| **ENVIRONMENT** | | | | |
| Food insecurity  Housing insecurity  Utilities support  Lead exposure  Transportation  Health insurance  Victim of bullying  Parental depression | Food assistance  Housing assistance  Utilities assistance  Lead info  Transportation assistance  Health insurance  Bullying  Mental health | | Food assistance  Housing assistance  Utilities assistance  Transportation assistance  Lead screening (PCP)  Health insurance  Mental health  Social worker | |
| **BEHAVIOR** | | | | |
| Aggression, tantrums, emotional dysregulation  Hyperactive/ impulsive  Focus/ attention problem  Anxiety/ worries/ fears  Depression  Self-injury  Elopement  Limited/ atypical social responsivity  Specific condition suspected | Safety  Anticipatory guidance  Behavior-specific guidance (Triggers of behavior, the why behind the behaviors, consequences)  Positive parenting strategies (Active ignores, Reflecting feelings)  Promoting independence and confidence | | Behavioral therapy (Applied behavioral analysis (ABA)  Mental Health  Early Intervention  Developmental Behavioral Pediatrician  Medical treatment of injuries (PCP) | |
| **EDUCATION** | | | | |
| Needs services  Existing services inadequate | Educational rights & advocacy  Individualized Education Plan (IEP)/ revision  504 plan/ revision | | School district evaluation request letter  Education psychologist  Neuropsychological/ psychoeducational testing | |
| **DEVELOPMENT** | | | | |
| Speech/ language/ communication delay  Fine motor delay  Gross motor delay  Cognitive/ problem-solving delay  Social-emotional delay  Global developmental delay  Adaptive skills delay | | Causes of developmental delays  Promoting development at home  Importance of acting early | | Early intervention  Developmental behavioral pediatrician  Neurology  Genetics  Mental health (early childhood)  Physical therapy  Occupational therapy  Speech/ language therapy  Developmental psychologist/ early childhood specialist  School psychologist  Adaptive sports |
| **NUTRITION/ GASTROINTESTINAL** | | | | |
| Overweight/ obesity  Underweight/Failure to thrive  Bowel movement disorders (constipation/diarrhea)  Restrictive diet/Picky eating | | Diet, nutrition, and physical activity  Feeding behavior, picky eating, food aversions  High fiber diet, constipation  Restrictive diet – nutritional deficiencies | | Gastroenterology  Endocrinology  Dietitian/ nutrition counseling  Occupational therapy |
| **SLEEP** | | | | |
| Behavioral insomnia  Obstructive sleep apnea | Sleep hygiene  Anticipatory guidance  Behavioral management | | Ears, Nose Throat (ENT)  Mental health/ child psychology  Sleep clinic (multidisciplinary) | |
| **VISION** | | | | |
| Decreased visual acuity  Strabismus/ amblyopia  Cataracts  Blindness | Blind resources  Strabismus/ amblyopia | | Ophthalmology  Optometry  Adaptive services | |
| **HEARING** | | | | |
| Chronic / serous otitis media  Suspected hearing loss  Deafness | Deaf resources | | Medical treatment (PCP)  Ears, Nose Throat (ENT)  Audiology  Adaptive services | |
| **DENTAL** | | | | |
| *Risk* for Early Childhood Caries (ECC) & Caries  Severe crowding and malocclusion  Dental caries | ECC prevention  Dental hygiene | | Dentist  Orthodontist  Oral surgeon | |
| **ENDOCRINE** | | | | |
| Thyroid problem  Diabetes | Diabetes | | Endocrine referral  PCP | |
| **GENETICS** | | | | |
| Global Dev Delay/ Intellectual Disability and/or Autism  Multiple dysmorphic features  Genetic syndrome suspected | Common causes of IDD, genetic testing recommendations | | Genetic screening  Dermatology | |
| **CARDIOVASCULAR** | | | | |
| Cardiac disease/murmur  High blood pressure | High blood pressure | | Cardiology  PCP | |
| **PULMONARY** | | | | |
| Asthma/ chronic lung disease  Signs of pulmonary hypertension | Asthma | | Pulmonology  Cardiology  Allergist | |
| **MUSCULOSKELETAL** | | | | |
| Scoliosis/lordosis/kyphosis  Joint contracture  Congenital foot deformity |  | | Orthopedics  Physical therapy | |
| **NEUROLOGICAL** | | | | |
| Suspected Increased intracranial pressure  Seizures/ epilepsy |  | | Neurology | |
| Other (free text): | Other (free text): | | Other (free text): | |

|  |
| --- |
| **Referral Details** |
| Click to add text here |

|  |
| --- |
| **Other** |
| Emergency care referral: detail |
| Emergency care rendered: detail |
| Child abuse reporting by state/ federal law: detail |

END OF SCREENING