



EPSDT Provider Toolkit



WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids*® members enrolled in the *Georgia Families*® program and women enrolled in the *Planning for Healthy Babies*® program.



What is EPSDT?

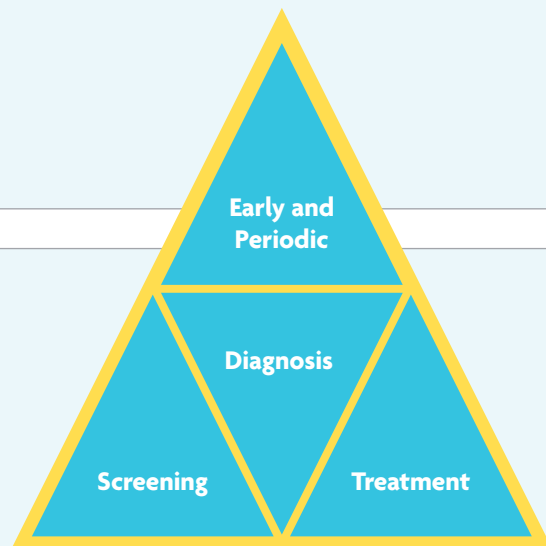
The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's federally mandated comprehensive array of preventive, diagnostic, and treatment services for individuals younger than 21. EPSDT benefit was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 and requires states to cover all services within the scope of the federal Medicaid program. The intent of the EPSDT benefit is to focus on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.

Services include:

- Preventive screening
- Diagnosis and treatment
- Transportation and scheduling assistance
- Follow-up care with specialists

Screening must include:

- Comprehensive health and developmental history (includes both physical and mental health)
- Comprehensive unclothed physical exam
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Health education, including anticipatory guidance
- Vision services
- Dental services
- Hearing services
- Other necessary healthcare – diagnostic services and treatment to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services



Schedules used to determine when services are due:

- American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule
- CDC Advisory Committee on Immunization Practices immunization recommendations schedule
- Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

The WellCare EPSDT program supports the individual state plans by:

- Providing a repository to house EPSDT data for reporting, tracking and trending
- Mailing annual preventive care recommendations and reminders to members and providers
- EPSDT Member Outreach Coordinators providing continuous care coordination for EPSDT services
- Providing Patient Care Advocates and Quality Practice Advisors to support members and provider practices
- Mailing referral letters and conducting outreach to coordinate follow-up care

WellCare's EPSDT program includes additional member and provider outreach activities, member and provider healthy behavior rewards, and targeted care management programs.



**If you have questions, contact your local
Provider Relations representative or call
Provider Services at 1-866-231-1821.**



| CPT | New Patient | CPT | Established Patient |
|-------|--------------------------------|-------|--------------------------------|
| 99381 | Preventive visit, Age < 1 year | 99391 | Preventive visit, Age < 1 year |
| 99382 | Preventive visit, Age 1-4 | 99392 | Preventive visit, Age 1-4 |
| 99383 | Preventive visit, Age 5-11 | 99393 | Preventive visit, Age 5-11 |
| 99384 | Preventive visit, Age 12-17 | 99394 | Preventive visit, Age 12-17 |
| 99385 | Preventive visit, Age 18-21 | 99395 | Preventive visit, Age 18-21 |

| Codes | Description |
|---------------|--|
| Z68.51-Z68.54 | BMI percentile (use for 2-20 years of age) |
| 97802-97804 | Medical nutrition therapy |
| Z02.5 | Encounter for examination for participation in sport |
| Z71.82 | Counseling for physical activity |
| Z71 | Persons encountering health services for other counseling and medical advice, not elsewhere classified |

A Note on Modifiers and Early Periodic Screens

Modifier 25

Modifier 25 is used to describe a significant and separately identifiable E/M service above and beyond the other service provided. When a standardized screen or assessment is administered along with any E/M service (e.g., preventive medicine service), both services should be reported and modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

Modifier 59

A 59 modifier is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. For example, when a maternal depression screen and a health risk assessment are performed in the same visit, the 59 modifier should be appended to CPT 96161. For more information on use of a '59' modifier, please click on the following link:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>

EP Modifier

An EP modifier is used to identify Early and Periodic Screens, and services provided in association with an Early and Periodic Screen, therefore any service provided in an Early and Periodic Screen should have an EP modifier. It is important to append an EP modifier to these services, as some of these CPT codes are also used for services provided to adults.



Immunization Billing Codes

| CPT | Description |
|-------------------------|---|
| 90460 | Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified healthcare professional; first or only component of each vaccine or toxoid administered |
| 90471 | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) |
| 90472+ (add-on-code) | Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure |
| 90473 | Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid) |
| 90474+ (add-on-code) | Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure |

Please Note:

- No intranasal vaccines are currently coverable per NCIP/VFC program (90672 - the Influenza virus vaccine (FluMist), quadrivalent, for intranasal use (2 years and older) should be covered).
- Currently, 90474 cannot be billed with 90473 as there are no two oral and/or intranasal vaccines or combination of an oral and intranasal vaccine that would be given to a recipient.
- 90460 is NOT a stand-alone immunization administration code and does have add-on-codes for additional vaccines (Although add-on codes (90472, 90474) may also be used in conjunction with the 90460 code, 90460 may be reported without add on codes.)
- Always append EP modifier to all vaccine administration codes, including 90460.
- For all vaccines administered after Oct. 1, 2015, providers should use ICD 10-CM code Z23.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Quick Reference Guide

Use the chart below to be sure your practice is following the appropriate age-specific guidelines.

| Children's Preventive Guidelines | Birth | 3-5 days | 1 month | 2 months | 4 months | 6 months | 9 months | 12 months | 15 months | 18 months | 24 months | 30 months | 3 years | 4 years | 5 years | 6 years | 7-21 years |
|---|-------|----------|---------|----------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|---------|---------|---------|---------|------------|
| History | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Height or length/weight | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Head circumference | • | • | • | • | • | • | • | • | • | • | • | | | | | | |
| Body mass index (percentile if < 16 years old) | | | | | | | | | | | • | • | • | • | • | • | Yearly |
| Blood pressure ¹ | * | * | * | * | * | * | * | * | * | * | * | * | • | • | • | • | Yearly |
| Nutrition assessment/counseling | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Physical activity assessment/counseling ² | | | | | | | | | | | | | • | • | • | • | Yearly |
| Vision exam | * | * | * | * | * | * | * | * | * | * | * | * | • | • | • | • | Yearly |
| Hearing exam | • | • | • | • | * | * | * | * | * | * | * | * | * | • | • | • | Yearly |
| Developmental assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Autism screening | | | | | | | | | | • | • | * | | | | | |
| Psychological/Behavioral assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Tobacco, Alcohol, or Drug Use Assessment | | | | | | | | | | | | | | | | | *11-21 |
| Physical exam (un clothed) | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Oral/Dental assessment | * | * | * | * | * | • | • | • | * | • | • | • | • | * | * | * | Yearly |
| Immunization assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Lead screening | | | | | | * | * | • | | * | • | | * | * | * | * | |
| Urinalysis | | | | | | | | | | | | | | | | • | 16 years |
| Tuberculin test if at risk | | | * | | | * | | * | | * | * | | * | * | | | * |
| Dyslipidemia screening | | | | | | | | | | | * | | | * | | | *17-21 |
| Sexually transmitted infection (STI) screening ⁴ | | | | | | | | | | | | | | | | | *11-21 |
| Cervical dysplasia screening ⁴ | | | | | | | | | | | | | | | | | *11-21 |
| Anticipatory guidance | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |
| Counseling/Referral for identified problems | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | Yearly |

¹Children with specific risk factors should have their blood pressure taken at visits before age 3. ²HEDIS® measure added to chart. ³Referrals for dental care should be given for any problem identified or if there is no dental home. AAPD recommends a dental exam every six months after tooth eruption. ⁴STI and cervical dysplasia screenings should be conducted on all sexually active females 11-21 years of age. *Conduct a risk assessment. If high-risk conditions exist, perform screening. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Notes:

- All well visits should include, at a minimum, an unclothed physical exam, developmental assessment, anticipatory guidance, and age-appropriate screenings and immunizations, as indicated.
- Health education should include counseling for issues and risk factors, as well as inform patients about the benefits of a healthy lifestyle, safety practices/accident avoidance and disease prevention.
- Screenings are as recommended by AAP and AAPD. An initial screening may be done at any time, even if the patient’s age does not correspond with the periodicity schedule.
- If you require assistance with the EPSDT services due, contact us at the address below:

WellCare of Georgia
211 Perimeter Center Parkway
Suite 800
Atlanta, GA 30346

Recommended EPSDT Periodicity Schedule

A visit should be scheduled for all new members within 60 days. Subsequent visits should be scheduled based on the recommended guidelines.

- | | | | |
|------------|------------|-------------|---------------|
| • 3-5 days | • 4 months | • 12 months | • 24 months |
| • 1 month | • 6 months | • 15 months | • 30 months |
| • 2 months | • 9 months | • 18 months | • 3-21 yearly |

Any member who has not had the recommended services should be brought up to date as soon as possible.



Helpful Hints

- Use the listing of members due or overdue for EPSDT services provided to you by WellCare and contact the member for an appointment.
- Maximize every visit by making sure the child is current on EPSDT services.
- Be sure your office uses the correct coding.

For complete information, see:

The American Academy of Pediatrics (AAP) periodicity schedule at <https://brightfutures.aap.org/clinical-practice/Pages/default.aspx> and the American Academy of Pediatric Dentistry (AAPD) guidelines at http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf





Immunizations

| Recommended Childhood Immunizations | Birth | 1 month | 2 months | 4 months | 6 months | 12 months | 15 months | 18 months | 23 months | 2-3 years | 4-6 years |
|-------------------------------------|-------|---------|----------|----------|------------------|---------------|-----------|-----------|-----------|----------------|-----------|
| Hepatitis B | Hep B | Hep B | | | Hep B | | | | | | |
| Rotavirus | | | RV | RV | | | | | | | |
| Diphtheria, Tetanus, Pertussis | | | DTap | DTap | DTap | | DTap | | | | DTap |
| Haemophilus Influenza Type b (Hib) | | | Hib | Hib | Hib | Hib | | | | | |
| Pneumococcal | | | PCV | PCV | PCV | PCV | | | | | PPSV |
| Inactivated Poliovirus | | | IPV | IPV | IPV | | | | | | IPV |
| Influenza | | | | | Influenza yearly | | | | | | |
| Measles, Mumps, Rubella | | | | | | MMR | | | | | MMR |
| Varicella | | | | | | Varicella | | | | | Varicella |
| Hepatitis A | | | | | | Hep A, dose 1 | | | | Hep A, dose 2* | |

■ Range of recommended ages for all children except certain high-risk groups

■ Range of recommended ages for certain high-risk groups

*6 months after dose 1



| Recommended Adolescent Immunizations | 7-10 years | 11-12 years | 13-18 years |
|--------------------------------------|------------------|---------------|-------------|
| Tetanus, Diphtheria, Pertussis | | Tdap | Tdap |
| Human Papillomavirus | | HPV (3 doses) | HPV series |
| Meningococcal | | MCV | MCV |
| Influenza | Influenza yearly | | |
| Pneumococcal | PPSV | | |
| Hepatitis A | Hep A series | | |
| Hepatitis B | Hep B series | | |
| Inactivated Poliovirus | IPV series | | |
| Measles, Mumps, Rubella | MMR series | | |
| Varicella | Varicella series | | |

■ Range of recommended ages for certain high-risk groups

■ Range of recommended ages for catch-up immunization



For complete information, see The Advisory Committee on Immunization Practices (<https://www.cdc.gov/vaccines/acip/recs/index.html>), the American Academy of Pediatrics (www.aap.org) and the American Academy of Family Physicians (www.aafp.org). Department of Health and Human Services • Centers for Disease Control and Prevention



Preventive Care Resources

| | |
|--------------------------------------|---|
| Georgia Department of Human Services | https://dhs.georgia.gov |
| Medicaid EPSDT Program | https://www.medicaid.gov/medicaid/benefits/epsdt/index.html |

| Prevention | |
|--|--|
| Adolescent Development | www.nlm.nih.gov/medlineplus/ency/article/002003.htm |
| Ages and Stages Questionnaires (a fee may be associated) | www.healthychildren.org |
| American Academy of Family Physicians | www.aafp.org |
| American Academy of Pediatrics – assessments, patient education, forms and other information | www.brightfutures.org |
| Centers for Disease Control and Prevention (CDC) Growth and BMI charts | www.cdc.gov/growthcharts/clinical_charts.htm |
| Health Resources and Service Administration (HRSA), Maternal and Child Health | www.mchb.hrsa.gov/epsdt |
| Georgia Breastfeeding Coalition | http://georgiabreastfeedingcoalition.org/ |

Prevention (Continued)

| | |
|--|---|
| March of Dimes | www.marchofdimes.com |
| Medicaid EPSDT Program | https://www.medicaid.gov/medicaid/benefits/epsdt/index.html |
| Modified Checklist for Autism in Toddlers (M-CHAT) autism screening tool | https://m-chat.org/ |
| National Domestic Violence Hotline | www.ndvh.org 1-800-799-SAFE (7233) |
| U.S. Department of Health and Human Services | www.healthfinder.gov/HealthTopics |

Immunizations

| | |
|---|---|
| CDC, Immunization Schedules | https://www.cdc.gov/vaccines/schedules/hcp/index.html |
| CDC, National Immunization Program | www.cdc.gov/vaccines |
| Immunization Action Coalition | www.immunize.org |
| Georgia Registry of Immunization Transactions and Services (G.R.I.T.S.) | https://www.grits.state.ga.us/production/security_ui.showLogin |
| Vaccine Safety | www.vaccinesafety.edu |

EPSDT Assessment Categories



Newborn Assessment

| Category | Assessment |
|-------------------------------------|--|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/Hemoglobinopathy |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Water source Well, city or bottled <input type="checkbox"/> Number of wet diapers/day <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Suck, swallow <input type="checkbox"/> Breathe easily <input type="checkbox"/> Turns, calms to mom's voice <input type="checkbox"/> Eats well |
| Common Problems | <input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Support for mother <input type="checkbox"/> Family makeup <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Any changes in family health <input type="checkbox"/> Maternal depression |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat, facing back <input type="checkbox"/> smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back <input type="checkbox"/> Well-fitted crib mattress, no pillows <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> No solid food <input type="checkbox"/> Sponge bath <input type="checkbox"/> Cord, circumcision care <input type="checkbox"/> Bowel movements <input type="checkbox"/> General newborn care <input type="checkbox"/> Taking temperature – Fever > 100.4° F <input type="checkbox"/> When to call the doctor |
| History | <input type="checkbox"/> Hospital course <input type="checkbox"/> Exams/Screenings <input type="checkbox"/> Hep B <input type="checkbox"/> Weeks' gestation <input type="checkbox"/> Birth weight <input type="checkbox"/> Issues/Concerns |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B #1 (if indicated) <input type="checkbox"/> Ophthalmology referral (if < 32 weeks) |



1-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/hemoglobinopathy <input type="checkbox"/> Tuberculosis |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Water source <input type="checkbox"/> Well, city or bottled <input type="checkbox"/> Number of wet diapers/day <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Lifts head when prone <input type="checkbox"/> Begins to smile <input type="checkbox"/> Follows parent with eyes <input type="checkbox"/> Turns to parent's voices |
| Common Problems | <input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development |
| Social/Family History | <input type="checkbox"/> Parent/Child adjustment <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Maternal depression <input type="checkbox"/> Support for mother <input type="checkbox"/> Sibling response to baby <input type="checkbox"/> Child care plans <input type="checkbox"/> Work plans <input type="checkbox"/> Violence or abuse |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Well-fitted crib mattress, no pillows <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Techniques to calm <input type="checkbox"/> Cord, circumcision care <input type="checkbox"/> Elimination <input type="checkbox"/> Taking temperature – Fever > 100.4° F <input type="checkbox"/> When to call the doctor <input type="checkbox"/> Avoid anything around baby's neck |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> TB test, if at risk |



2-Month Assessment

| Category | Assessment |
|---|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/hemoglobinopathy |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source <input type="checkbox"/> Well, city or bottled <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Begins to push up when prone <input type="checkbox"/> Holds head up when held <input type="checkbox"/> Begins to smile <input type="checkbox"/> Follows parent with eyes <input type="checkbox"/> Turns to parent's voice <input type="checkbox"/> Coos <input type="checkbox"/> Self-comfort <input type="checkbox"/> Cries when bored (no activity) <input type="checkbox"/> Symmetrical movement |
| Common Problems | <input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development |
| Social/Family History | <input type="checkbox"/> Parent/Child adjustment <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Maternal depression <input type="checkbox"/> Support for mother <input type="checkbox"/> Sibling response to baby <input type="checkbox"/> Child care plans <input type="checkbox"/> Working out of the home <input type="checkbox"/> Violence or abuse |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Bath safety <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Crib safety <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Delay solids <input type="checkbox"/> Elimination <input type="checkbox"/> Techniques to calm <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> When to call the doctor |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed |



4-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk assessment |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source <input type="checkbox"/> Well, city or bottled <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Push up to elbows when prone <input type="checkbox"/> Head control <input type="checkbox"/> Rolls and reaches for objects <input type="checkbox"/> Responds to affection <input type="checkbox"/> Babbles and coos <input type="checkbox"/> Self-comfort |
| Common Problems | <input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Working out of the home <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Bath safety <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Crib safety <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Weight gain <input type="checkbox"/> Elimination <input type="checkbox"/> Solid foods – when and how to add <input type="checkbox"/> Weight gain <input type="checkbox"/> Elimination Walkers <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> Choking |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed |



6-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk assessment <input type="checkbox"/> Tuberculosis risk screening <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source <input type="checkbox"/> Well, city or bottled <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Able to sit briefly <input type="checkbox"/> Head control <input type="checkbox"/> Rolls and reaches for objects <input type="checkbox"/> Responds to affection <input type="checkbox"/> Jabbers and laughs <input type="checkbox"/> Self-comfort <input type="checkbox"/> Puts things in mouth |
| Common Problems | <input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Working out of the home <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Drowning <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Kitchen safety <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Solid foods – when and how to add <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Elimination <input type="checkbox"/> Walkers <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Teething |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> Lead screening, if at risk <input type="checkbox"/> TB test, if at risk <input type="checkbox"/> Fluoride, if indicated |



9-Month Assessment

| Category | Assessment |
|---|--|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Developmental screening |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source <input type="checkbox"/> Well, city, bottled, fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Sits well <input type="checkbox"/> Pulls to stand <input type="checkbox"/> Crawls <input type="checkbox"/> Imitates sounds <input type="checkbox"/> Plays peek-a-boo <input type="checkbox"/> Puts things in mouth <input type="checkbox"/> Looks for dropped items |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Goes to parent for comfort <input type="checkbox"/> Stranger anxiety |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Burns <input type="checkbox"/> Drowning <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> No bottle in bed or propping <input type="checkbox"/> First dental visit <input type="checkbox"/> Child-proof home <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Solid foods <input type="checkbox"/> Self-feeding <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Falls/Window guards <input type="checkbox"/> Poisons <input type="checkbox"/> No TV <input type="checkbox"/> Teething |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B <input type="checkbox"/> Catch up immunizations <input type="checkbox"/> Dental, if at risk <input type="checkbox"/> Lead screening, if at risk <input type="checkbox"/> Fluoride, if indicated |



12-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia screening <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening <input type="checkbox"/> TB risk assessment |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source Well, city, bottled, fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC <input type="checkbox"/> Weaned |
| Development | <input type="checkbox"/> Waves bye <input type="checkbox"/> Pulls to stand, walks holding on <input type="checkbox"/> Copies gestures <input type="checkbox"/> Imitates sounds <input type="checkbox"/> Plays peek-a-boo <input type="checkbox"/> Follows simple directions <input type="checkbox"/> Speaks one or two words <input type="checkbox"/> Drinks from a cup |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Praise for good behavior <input type="checkbox"/> Stranger anxiety <input type="checkbox"/> Separation anxiety |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Burns <input type="checkbox"/> Drowning <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> No bottle in bed or propping <input type="checkbox"/> Weaning <input type="checkbox"/> Child-proof home <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Solid foods <input type="checkbox"/> Self-feeding <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Falls/Window guards <input type="checkbox"/> Poisons <input type="checkbox"/> No TV |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes/Concerns – child health <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Varicella, PCV-7, Hib, Hep B, Hep A, IPV, MMR, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> TB test, if at risk <input type="checkbox"/> Hematocrit or hemoglobin |



15-Month Assessment

| Category | Assessment |
|---|---|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision |
| Nutrition | <input type="checkbox"/> Breast, how long, frequency <input type="checkbox"/> Formula, oz and frequency Brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source Well, city, bottled, fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC <input type="checkbox"/> Weaned |
| Development | <input type="checkbox"/> Says two or three words <input type="checkbox"/> Walks well <input type="checkbox"/> Bends down without falling <input type="checkbox"/> Scribbles <input type="checkbox"/> Tries to do what others do <input type="checkbox"/> Follows simple commands <input type="checkbox"/> Listens to a story <input type="checkbox"/> Puts a block in a cup |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums <input type="checkbox"/> Discourage hitting, biting, other aggressive behaviors |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> First dentist visit <input type="checkbox"/> Puts a block in a cup <input type="checkbox"/> Healthy food/snack choices <input type="checkbox"/> Whole milk <input type="checkbox"/> Falls <input type="checkbox"/> Poisons <input type="checkbox"/> No TV |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> MMR, Hib, Varicella, PCV-7 Hep B, Hep A, DTaP, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> TB test, if at risk |



18-Month Assessment

| Category | Assessment |
|---|--|
| Physical Exam | <input type="checkbox"/> Weight, length – W/L percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk assessment <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Autism screening <input type="checkbox"/> Developmental screening |
| Nutrition | <input type="checkbox"/> Weaned, bottle, breast <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source Well, city, bottled, fluoridated <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Says six words <input type="checkbox"/> Walks up steps <input type="checkbox"/> Runs <input type="checkbox"/> Laughs in response to others <input type="checkbox"/> Points to one body part <input type="checkbox"/> Uses spoon and cup <input type="checkbox"/> Stacks two blocks <input type="checkbox"/> Points at objects <input type="checkbox"/> Helps to dress/undress |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums – timeouts <input type="checkbox"/> Discourage hitting, biting, other aggressive behaviors |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read, sing to baby |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home (i.e. electrical outlets, locks) <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> First dentist visit <input type="checkbox"/> Healthy food/snack choices <input type="checkbox"/> Whole milk <input type="checkbox"/> Falls <input type="checkbox"/> Poisons <input type="checkbox"/> No TV <input type="checkbox"/> Toilet training readiness |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, MMR, Hep B, Hep A, <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Lead screen, if at risk <input type="checkbox"/> TB test, if at risk |



24-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Height/weight % – W/H % <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk assessment <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Autism screening <input type="checkbox"/> Dyslipidemia risk assessment |
| Nutrition | <input type="checkbox"/> Weaned off bottle, breast <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source Well, city, bottled, fluoridated <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Says 6 words <input type="checkbox"/> Stands on tiptoe <input type="checkbox"/> Runs <input type="checkbox"/> Knows names of familiar people and body parts <input type="checkbox"/> Plays alongside other children <input type="checkbox"/> Throws a ball overhand <input type="checkbox"/> Stacks 5-6 blocks <input type="checkbox"/> Turns pages of book one at a time |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums – timeouts <input type="checkbox"/> Playing with other children <input type="checkbox"/> Self-expression |
| Social/Family History | <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read, sing to bab <input type="checkbox"/> Model appropriate language <input type="checkbox"/> Screen time |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Picky eater <input type="checkbox"/> Supervise outside <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day <input type="checkbox"/> Toilet training |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep A, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> Autism screening <input type="checkbox"/> Lipid profile, if at risk <input type="checkbox"/> TB test, if at risk |



30-Month Assessment

| Category | Assessment |
|-------------------------------------|---|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental home <input type="checkbox"/> Developmental screening |
| Nutrition | <input type="checkbox"/> Weaned, bottle, breast <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source <input type="checkbox"/> Well, city, bottled or fluoridated <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Puts 3-4 words together <input type="checkbox"/> Jumps up and down <input type="checkbox"/> Washes and dries hands <input type="checkbox"/> Knows animal sounds |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hours <input type="checkbox"/> Temperament <input type="checkbox"/> Set limits |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Child care type <input type="checkbox"/> Daily reading <input type="checkbox"/> Preschool |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Outdoor safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Picky eater <input type="checkbox"/> Supervise outside <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day <input type="checkbox"/> Toilet training |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral |



3-Year Assessment

| Category | Assessment |
|-------------------------------------|--|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental referral <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Tuberculosis risk screening |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source Well, city, bottled, fluoridated <input type="checkbox"/> WIC |
| Development | <input type="checkbox"/> Puts 2-3 sentences together <input type="checkbox"/> Stands on 1 foot <input type="checkbox"/> Knows if boy or girl <input type="checkbox"/> Names objects <input type="checkbox"/> Imaginary play |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hours <input type="checkbox"/> Manage anger <input type="checkbox"/> Reinforce good behavior |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Child care type <input type="checkbox"/> Read, sing, play <input type="checkbox"/> Preschool <input type="checkbox"/> Family activities <input type="checkbox"/> Parent/Child interaction |
| Anticipatory Guidance Topics | <input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Child-proof home <input type="checkbox"/> Outdoor safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Supervise outside, street safety <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hours/day |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental referral |



4-Year Assessment

| Category | Assessment |
|---|--|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR - BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing-Audiometry <input type="checkbox"/> Vision <input type="checkbox"/> Dyslipidemia risk assessment <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Tuberculosis risk screening <input type="checkbox"/> Assess: Language/Speech Fine/Gross motor skills Gait |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source Well, city, bottled, fluoridated |
| Development | <input type="checkbox"/> Puts 2-3 sentences together <input type="checkbox"/> Hops on 1 foot <input type="checkbox"/> Knows name, age and gender <input type="checkbox"/> Names 4 colors <input type="checkbox"/> Dresses self <input type="checkbox"/> Brushes own teeth <input type="checkbox"/> Draws a person |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hrs <input type="checkbox"/> Curiosity about sex |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Preschool <input type="checkbox"/> Family activities <input type="checkbox"/> Parent/Child interaction <input type="checkbox"/> Helps at home |
| Anticipatory Guidance Topics | <input type="checkbox"/> Appropriate car restraints <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Safety rules with adults <input type="checkbox"/> Daily reading <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Outside supervision and street safety <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Lipid profile, if at risk <input type="checkbox"/> Audiometry |



5- to 6-Year Assessment

| Category | Assessment |
|-------------------------------------|--|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing-Audiometry <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Dental assessment <input type="checkbox"/> Assess: Language/Speech Fine/Gross motor skills Gait |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source Well, city, bottled, fluoridated |
| Development | <input type="checkbox"/> Good language skills <input type="checkbox"/> Speaks clearly <input type="checkbox"/> Balances on 1 foot <input type="checkbox"/> Ties a knot <input type="checkbox"/> Counts to 10 <input type="checkbox"/> Copies squares and triangles <input type="checkbox"/> Draws a person (6 parts) |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Attention <input type="checkbox"/> Social interaction <input type="checkbox"/> Cooperation/Oppositional <input type="checkbox"/> Sleep |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/Child/Sibling <input type="checkbox"/> Interaction <input type="checkbox"/> School readiness <input type="checkbox"/> Family time |
| Anticipatory Guidance Topics | <input type="checkbox"/> Appropriate booster/car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV <input type="checkbox"/> Healthy weight <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, MMR, Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental referral <input type="checkbox"/> Audiometry |



7- to 8-Year Assessment

| Category | Assessment |
|---|---|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Tobacco/Alcohol/Drug Use Assessment |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source Well, city, bottled, fluoridated |
| Development | <input type="checkbox"/> Good hand-eye coordination <input type="checkbox"/> Enjoys hobbies and collecting <input type="checkbox"/> Uses reflective thinking <input type="checkbox"/> May experience guilt/shame |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/learning <input type="checkbox"/> Participates in after-school activities <input type="checkbox"/> Doing well in school <input type="checkbox"/> Homework <input type="checkbox"/> Sleep |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/child/sibling interaction <input type="checkbox"/> Parent/Teacher concerns <input type="checkbox"/> Eats meals as a family |
| Anticipatory Guidance Topics | <input type="checkbox"/> Appropriate booster/Car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets and pads <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated |



9- to 10-Year Assessment

| Category | Assessment |
|---|--|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Dyslipidemia screening <input type="checkbox"/> Tobacco/Alcohol/Drug Use Assessment |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source <input type="checkbox"/> Well, city, bottled or fluoridated |
| Development | <input type="checkbox"/> Rough and tumble play <input type="checkbox"/> Enjoys team games <input type="checkbox"/> Likes complex crafts and tasks <input type="checkbox"/> Ability to learn and apply skills <input type="checkbox"/> Capable of longer interest <input type="checkbox"/> More abstract reasoning |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/learning <input type="checkbox"/> Self-control <input type="checkbox"/> Sense of accomplishment <input type="checkbox"/> Competitive |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/Teacher concerns <input type="checkbox"/> More independent <input type="checkbox"/> Very conscious of fairness |
| Anticipatory Guidance Topics | <input type="checkbox"/> Appropriate booster/car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets and pads <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated |



11- to 14-Year Assessment

| Category | Assessment |
|---|---|
| Physical Exam | <input type="checkbox"/> Height/weight % – BMI percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Tobacco/Alcohol/Drug Use Assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy – including low-fat options <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source <input type="checkbox"/> Well, city, bottled or fluoridated |
| Development | <input type="checkbox"/> Pubic and underarm hair growth <input type="checkbox"/> Girls: Breast development/Menarche/Rapid growth spurt <input type="checkbox"/> Boys: Voice changes/Genital growth/Nocturnal emissions <input type="checkbox"/> Understands abstract ideas |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Develop moral philosophies <input type="checkbox"/> Self-esteem <input type="checkbox"/> Sexual activity |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> After-school activities <input type="checkbox"/> Family relationships |
| Anticipatory Guidance Topics | <input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety – helmets, water <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying <input type="checkbox"/> Adequate sleep <input type="checkbox"/> Stress management <input type="checkbox"/> Anger management |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated |



15- to 17-Year Assessment

| Category | Assessment |
|-------------------------------------|--|
| Physical Exam | <input type="checkbox"/> H/W percentile – BMI percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-carries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Tobacco/Alcohol/Drug Use Assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening <input type="checkbox"/> HIV Test/Screening |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Low-fat dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source Well, city, bottled, fluoridated |
| Development | <input type="checkbox"/> Girls – full physical development <input type="checkbox"/> Boys – voice lowers, facial hair, muscle gain and height <input type="checkbox"/> Interest in new music, fashion <input type="checkbox"/> Solve problems <input type="checkbox"/> More aware – sexual orientation <input type="checkbox"/> Plans for future work/education |
| Behavioral/Social | <input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Challenge school/parents rules <input type="checkbox"/> Dissatisfied with appearance |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> More time with friends or alone <input type="checkbox"/> Begins interest in religion, politics, causes <input type="checkbox"/> Seeks more control over life <input type="checkbox"/> Positive family relationships |
| Anticipatory Guidance Topics | <input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety – helmets, water <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Anger management |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated |



18- to 21-Year Assessment

| Category | Assessment |
|---|---|
| Physical Exam | <input type="checkbox"/> H/W percentile – BMI <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Teeth-caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro |
| Risk Assessment/ Screening | <input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Tobacco/Alcohol/Drug Use Assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening |
| Nutrition | <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Low-fat dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source Well, city, bottled, fluoridated |
| Development | <input type="checkbox"/> Girls – full physical development <input type="checkbox"/> Boys – may continue to gain muscle and height <input type="checkbox"/> Sense of self <input type="checkbox"/> Self-reliant <input type="checkbox"/> Makes own decisions <input type="checkbox"/> Sets goals <input type="checkbox"/> Plans for future work/education |
| Behavioral/Social | <input type="checkbox"/> Responsibility for actions <input type="checkbox"/> Coping skills |
| Social/Family History | <input type="checkbox"/> Changes since last visit <input type="checkbox"/> Concern about relationships <input type="checkbox"/> Living on their own |
| Anticipatory Guidance Topics | <input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> Work stress <input type="checkbox"/> Safe sex <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs <input type="checkbox"/> Oral hygiene <input type="checkbox"/> No texting while driving <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Stress management |
| History | <input type="checkbox"/> Follow-up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health |
| Plan/Referrals | <input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Lipid profile <input type="checkbox"/> TB test, if at risk |



2019 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

| NQF # | Measure Steward | Measure Name |
|--|-----------------|--|
| Primary Care Access and Preventive Care | | |
| 0024 | NCQA | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH) |
| 0033 | NCQA | Chlamydia Screening in Women Ages 16–20 (CHL-CH) |
| 0038 | NCQA | Childhood Immunization Status (CIS-CH) |
| 0418/0418e | CMS | Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) |
| 1392 | NCQA | Well-Child Visits in the First 15 Months of Life (W15-CH) |
| 1407 | NCQA | Immunizations for Adolescents (IMA-CH) |
| 1448* | OHSU | Developmental Screening in the First Three Years of Life (DEV-CH) |
| 1516 | NCQA | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH) |
| NA | NCQA | Adolescent Well-Care Visits (AWC-CH) |
| NA | NCQA | Children and Adolescents’ Access to Primary Care Practitioners (CAP-CH) |
| Maternal and Perinatal Health | | |
| 0139 | CDC | Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH) |
| 0471 | TJC | PC-02: Cesarean Birth (PC02-CH) |

(continued on next page)

| NQF # | Measure Steward | Measure Name |
|--|-----------------|--|
| Maternal and Perinatal Health Continued | | |
| 1360 | CDC | Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH) |
| 1382 | CDC | Live Births Weighing Less Than 2,500 Grams (LBW-CH) |
| 1517* | NCQA | Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH) |
| 2902 | OPA | Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH) |
| 2903/2904 | OPA | Contraceptive Care – All Women Ages 15–20 (CCW-CH) |
| Care of Acute and Chronic Conditions | | |
| 1800 | NCQA | Asthma Medication Ratio: Ages 5–18 (AMR-CH) |
| NA | NCQA | Ambulatory Care: Emergency Department (ED) Visits (AMB-CH) |
| Behavioral Health Care | | |
| 0108 | NCQA | Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) |
| 0576 | NCQA | Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) |
| 2801 | NCQA | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) |
| NA | NCQA | Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) |
| Dental and Oral Health Services | | |
| 2508* | DQA (ADA) | Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH) |
| NA | CMS | Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) |
| Experience of Care | | |
| NA | NCQA | Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) |

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf>.

* This measure is no longer endorsed by NQF.

CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

Please refer to available state forms or resources below for forms and information on use.

Please note: This document contains general screening, guidelines and topics to assist with examination and documentation of well-child exams.

For more detailed information, risk assessments, forms and information contained therein, go to:

- American Academy of Pediatrics - www.aap.org
- The Advisory Committee on Immunization Practices - <https://www.cdc.gov/vaccines/acip/recs/index.html>
- The American Academy of Family Physicians - www.aafp.org
- Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).
See page 32 and 33 for reference

