PATIENT NAME_____**DATE OF BIRTH**_____

VISION RISK ASSESSMENT BIRTH TO 3 YEARS

1. Does your infant or child wear eye glasses? Y N
2. If so, when was their last eye exam? _____
3. Does your child seem to see well? Y N
4. Does your child hold objects close to their face when trying to focus? Y N
5. Do your child's eyes appear unusual or seem to cross, drift or be lazy? Y N
6. Do your child's eyelids droop or does one eyelid tend to close? Y N
7. Have your child's eyes ever been injured? Y N

(PHYSICIAN USE ONLY)

COMMENTS: NO SCREENING NEEDED

REFER TO OPTHAMOLOGY

Eye Consultants of Atlanta
Scottish Rite 404-255-2419
Marietta 770-424-5669

Cartersville Pediatric Associates
958A Joe Frank Harris Pkwy
Cartersville, GA 30120

Provider Signature:_____

Patient Name: _____ **Date of Birth:** _____

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk? Yes No		
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No

Provider Signature: _____ **Date:** _____

LEAD RISK ASSESSMENT QUESTIONNAIRE

Please check "Yes" or "No" for the following questions:	YES	NO
1. Does your child live in a house/apartment that was built before 1960?	☐	☐
2. Does your child live in a house/apartment that was built before 1978, that is being remodeled at this time?	☐	☐
3. Does anyone living with your child ever had elevated lead levels?	☐	☐
4. Does anyone living with your child work in a lead industry (radiator shop or battery manufacturer) or have a hobby that uses lead (welder, painter, etc.)?	☐	☐
5. Does your child eat paint chips or any non-food items or play in dirt where cars have been parked?	☐	☐
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?	☐	☐
7. Are home remedies such as greta, azarcon, or pay-loo-ah, or cosmetics with kohl in them used in your home?	☐	☐
8. Does anyone in the family use cosmetics, ethnic or folk remedies, or eat candy from Mexico?	☐	☐
9. Is your child a recent immigrant, refugee, or a member of a minority group?	☐	☐

COMMENTS: If there is an answer to YES or UNKNOWN to any of the questions above.

TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE

	YES	NO
1. Is your child in close contact of a person with infectious tuberculosis?	☐	☐
2. Does your child have HIV infection or is he/she considered at risk for HIV infection?	☐	☐
3. Is your child foreign born (especially Asian, African, Latin American), a refugee or a migrant?	☐	☐
4. Is your child in contact with an incarcerated person or a person who was incarcerated in the past five (5) years?	☐	☐
5. Is your child exposed to the following individuals: HIV infected, homeless individuals, residents of nursing homeless, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults or migrant farm workers?	☐	☐
6. Does your child have a medical condition or treatment of a medical condition which suppresses the immune system?	☐	☐
7. Does your child live in a community in which it has been established that a high risk exists for tuberculosis?	☐	☐
8. Other _____		

(Individuals treated for tuberculosis or currently active should not be tested.)

Any "yes" answer means the child is high risk, should receive a tuberculin skin test (Mantoux) which should be read by a health professional and the Public Health Department should be notified. (See section 902.2j)

Patient Name: _____

Date of Birth: _____

Age: _____

PROVIDER SIGNATURE:_____

Today's Date: _____

CARTERSVILLE PEDIATRIC ASSOCIATES

SCREENING FOR TB DISEASE AND INFECTION

In general, high-risk groups that should screened for infection include:

- Close contacts of persons with infectious TB;
- Persons with HIV infection or risk factors for HIV for unknown HIV status;
- Persons with certain medical conditions (including cancer of head and neck, Hematologic and reticuloendothelial diseases, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndromes, prolonged corticosteroid therapy, and other immunosuppressive therapy);
- Persons who inject drugs;
- Foreign-born persons from areas of the world where TB is common (e.g., Asia, Africa, Latin American);
- Medically underserved low income populations, including high risk ration and ethnic groups (e.g., Asians, Pacific Islanders, Blacks, Hispanics, and Native Americans);
- Residents or long-term care facilities (e.g., correctional facilities and nursing homes); or
- Other groups identified locally as having an increased prevalence of Tb (e.g., migrant Farm workers or homeless persons).

TUBERCULIN SKIN TESTING

Mantoux tuberculin skin testing is the standard method of identifying persons infected with M. tuberculosis. Multiple punctures tests should not be used to determine whether a person is infected.

The Mantoux test is performed by giving an intradermal injection of 0.1ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable tuberculin syringe, just beneath the surface of the skin, with the needle bevel facing upward. This should produce a discrete, pale elevation of the skin (a wheal) 6mm to 10mm in diameter.

The reaction to the Mantoux test should be read by the trained health care worker 48 to 72 hours after the injection. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing. However, if a patient who fails to return within 72 hours has a negative, tuberculin testing should be repeated.

The area of induration (palpable swelling) around the site of injection is the reaction to Tuberculin. The diameter of the indurated area should be measured across the forearm (perpendicular to the long axis). Erythema (redness) should not be measured. All reaction should be recorded in millimeters of induration, even those classified as negative. If no induration is found, “0mm” should be recorded.

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
Second Edition
By **Diane Bricker** and **Jane Squires**
with assistance from ***Linda Mounts, LaWanda Potter, Robert Nickel, Elizabeth Twombly,*** *and* ***Jane Farrell***

• 18 Month • Questionnaire

On the following pages are questions about activities children do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please check the box that tells whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Be sure to try each activity with your child before checking a box.
- ☑ Try to make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested, fed, and ready to play.
- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Look forward to filling out another questionnaire in _____ months.

ASQ™

Ages & Stages Questionnaires®: A Parent-Completed, Child-Monitoring System
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• 18 Month • Questionnaire

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Child's corrected date of birth (if child is premature, add weeks of prematurity to child's date of birth):

_____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ™

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, score "yes" for the item.

	YES	SOMETIMES	NOT YET	

COMMUNICATION *Be sure to try each activity with your child.*

1. When your child wants something, does she tell you by *pointing* to it?	❑	❑	❑	___
2. When you ask him to, does your child go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat" or "Go get your blanket.")	❑	❑	❑	___
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	❑	❑	❑	___
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Check "yes" even if her words are difficult to understand.)	❑	❑	❑	___
5. Without showing him first, does your child *point* to the correct picture when you say, "Show me the kitty" or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	❑	❑	❑	___
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "Bye-bye," "All gone," "All right," and "What's that?")	❑	❑	❑	___

Please give an example of your child's word combinations:

_____

COMMUNICATION TOTAL ___

GROSS MOTOR *Be sure to try each activity with your child.*

1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?	❑	❑	❑	___
2. Does your child move around by walking, rather than by crawling on her hands and knees?	❑	❑	❑	___
3. Does your child walk well and seldom fall?	❑	❑	❑	___
4. Does your child climb on an object such as a chair to reach something he wants?	❑	❑	❑	___
5. Does your child walk down stairs if you hold onto one of her hands? (You can look for this at a store, on a playground, or at home.)	❑	❑	❑	___
6. When you show him how to kick a large ball, does your child try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, check "yes" for this item.) 	❑	❑	❑	___

GROSS MOTOR TOTAL ___

	YES	SOMETIMES	NOT YET	

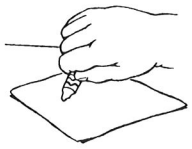
FINE MOTOR *Be sure to try each activity with your child.*

1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, check "not yet" for this item.)

❑ ❑ ❑ ___

2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.) ❑ ❑ ❑ ___

3. Does your child make a mark on the paper with the *tip* of a crayon (or pencil or pen) when trying to draw?



❑ ❑ ❑ ___

4. Does your child stack three small blocks or toys on top of each other by herself? (You can also use spools of thread, small boxes, or toys that are about 1 inch in size.) ❑ ❑ ❑ ___

5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.) ❑ ❑ ❑ ___

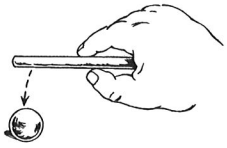
6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill? ❑ ❑ ❑ ___

FINE MOTOR TOTAL ___

PROBLEM SOLVING *Be sure to try each activity with your child.*

1. Does your child drop several (six or more) small toys into a container, such as a bowl or box? (You may show him how to do it.) ❑ ❑ ❑ ___

2. After you have shown her how, does your child try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



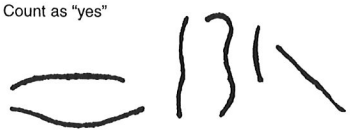
❑ ❑ ❑ ___

3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child purposely turn the bottle over to dump it out? You may show him how to do this. You can use a plastic soda-pop bottle or baby bottle. ❑ ❑ ❑ ___

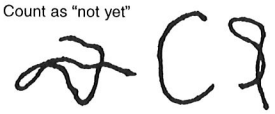
4. Without first showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)? ❑ ❑ ❑ ___

5. After he watches you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in *any direction?* (Scribbling back and forth does not count as "yes.")

Count as "yes"



Count as "not yet"



❑ ❑ ❑ ___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show her how.) (Please allow a few minutes between trying problem solving items 3 and 6.)	❑	❑	❑	___ *

PROBLEM SOLVING TOTAL ___

**If problem solving item 6 is marked "yes" or "sometimes," mark problem solving item 3 as "yes."*

PERSONAL-SOCIAL *Be sure to try each activity with your child.*

1. While looking at himself in the mirror, does your child offer a toy to his own image?	❑	❑	❑	___
2. Does your child play with a doll or stuffed animal by hugging it?	❑	❑	❑	___
3. Does your child get your attention or try to show you something by pulling on your hand or clothes?	❑	❑	❑	___
4. Does your child come to you when she needs help, such as with winding up a toy or unscrewing a lid from a jar?	❑	❑	❑	___
5. Does your child drink from a cup or glass, putting it down again with little spilling?	❑	❑	❑	___
6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	❑	❑	❑	___

PERSONAL-SOCIAL TOTAL ___

OVERALL *Parents and providers may use the space at the bottom of the next sheet for additional comments.*

1. Do you think your child hears well? YES ❑ NO ❑
   If no, explain: _____
2. Do you think your child talks like other toddlers his age? YES ❑ NO ❑
   If no, explain: _____
3. Can you understand most of what your child says? YES ❑ NO ❑
   If no, explain: _____
4. Do you think your child walks, runs, and climbs like other toddlers her age? YES ❑ NO ❑
   If no, explain: _____
5. Does either parent have a family history of childhood deafness or hearing impairment? YES ❑ NO ❑
   If yes, explain: _____

OVERALL *(continued)*

6. Do you have concerns about your child's vision? YES ❑ NO ❑

   If yes, explain: _____

7. Has your child had any medical problems in the last several months? YES ❑ NO ❑

   If yes, explain: _____

8. Does anything about your child worry you? YES ❑ NO ❑

   If yes, explain: _____

18 Month ASQ Information Summary

Child's name: _____ Date of birth: _____

Person filling out the ASQ: _____ Corrected date of birth: _____

Mailing address: _____ Relationship to child: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ completion: _____

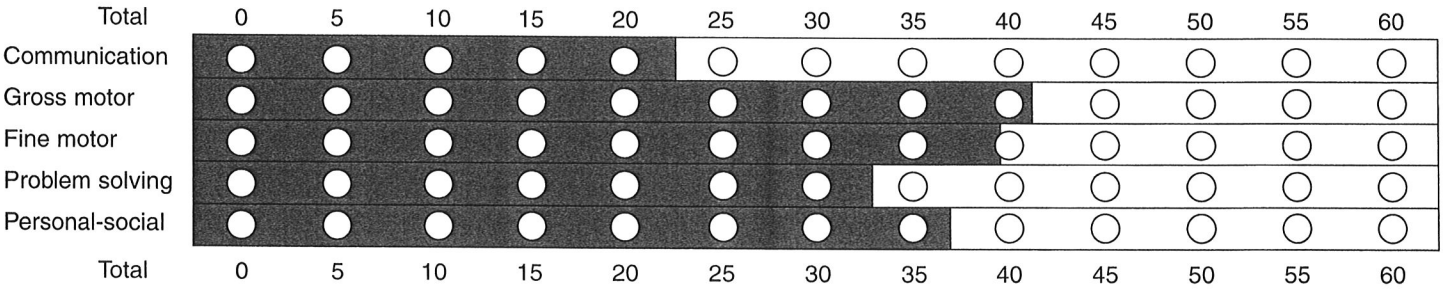
Today's date: _____ _____

OVERALL: Please transfer the answers in the Overall section of the questionnaire by circling "yes" or "no" and reporting any comments.

1. Hears well? YES NO
   Comments:
2. Talks like other toddlers? YES NO
   Comments:
3. Understand child? YES NO
   Comments:
4. Walks, runs, and climbs like others? YES NO
   Comments:
5. Family history of hearing impairment? YES NO
   Comments:
6. Vision concerns? YES NO
   Comments:
7. Recent medical problems? YES NO
   Comments:
8. Other concerns? YES NO
   Comments:

SCORING THE QUESTIONNAIRE

1. Be sure each item has been answered. If an item cannot be answered, refer to the ratio scoring procedure in *The ASQ User's Guide.*
2. Score each item on the questionnaire by writing the appropriate number on the line by each item answer.
   YES = 10 SOMETIMES = 5 NOT YET = 0
3. Add up the item scores for each area, and record these totals in the space provided for area totals.
4. Indicate the child's total score for each area by filling in the appropriate circle on the chart below. For example, if the total score for the Communication area was 50, fill in the circle below 50 in the first row.



Examine the blackened circles for each area in the chart above.

5. If the child's total score falls within the ▭ area, the child appears to be doing well in this area at this time.
6. If the child's total score falls within the ▬ area, talk with a professional. The child may need further evaluation.

OPTIONAL: The specific answers to each item on the questionnaire can be recorded below on the summary chart.

18 months

	Score	Cutoff
Communication		23.0
Gross motor		41.5
Fine motor		39.5
Problem solving		33.0
Personal-social		37.0

Communication	Gross motor	Fine motor	Problem solving	Personal-social
1 ○○○	1 ○○○	1 ○○○	1 ○○○	1 ○○○
2 ○○○	2 ○○○	2 ○○○	2 ○○○	2 ○○○
3 ○○○	3 ○○○	3 ○○○	3 ○○○	3 ○○○
4 ○○○	4 ○○○	4 ○○○	4 ○○○	4 ○○○
5 ○○○	5 ○○○	5 ○○○	5 ○○○	5 ○○○
6 ○○○	6 ○○○	6 ○○○	6 ○○○	6 ○○○
Y S N	Y S N	Y S N	Y S N	Y S N

Administering program or provider: _____