BIRTH & BEYOND PEDIATRICS P.C.

DEVELOPMENTAL SCREENING
24 MONTHS

Patient Name: _____ Date of Birth: ____ /____ /____

Please tell me any concerns, questions, problems you have about the way your child is behaving, developing/growth and/or learning:

_____

_____

DEVELOPMENTAL QUESTIONS AND OBSERVATIONS

☐ YES ☐ NO My toddler points to pictures.
☐ YES ☐ NO My toddler smiles, laughs, protests and says "NO".
☐ YES ☐ NO My toddler uses 2-3 word phrases.
☐ YES ☐ NO My toddler "pretend" plays.
☐ YES ☐ NO My toddler can stack 5-6 blocks.
☐ YES ☐ NO My toddler can kick a ball.

Describe his/her diet by checking all that apply: Rich in ☐ Meat ☐ Egg ☐ Iron fortified ☐ Cereal ☐ Breads

DEVELOPMENTAL MILESTONES

TODDLER DEVELOPMENT

Understands 2-step verbal commands ☐ YES ☐ NO
Imitates adults ☐ YES ☐ NO
Uses words to communicate with others ☐ YES ☐ NO
Vocabulary of at least 20 words/joins words ☐ YES ☐ NO
Points to 6 named body parts *(nose, eyes Ears, mouth, hands, feet, tummy, hair)* ☐ YES ☐ NO
Washes and dries hands ☐ YES ☐ NO
Helps with brushing teeth ☐ YES ☐ NO

PARENT DEVELOPMENT

Appropriately disciplines toddler ☐ YES ☐ NO
Positively talks, listens and responds to toddler ☐ YES ☐ NO
Parent is loving toward toddler ☐ YES ☐ NO
Uses words to tell toddler what is coming next ☐ YES ☐ NO

TUBERCULOSIS

Was your child born in a country at high risk for tuberculosis *(countries other than the United States, Canada, Australia, New Zealand or Western Europe)*? ☐ YES ☐ NO

Has your child traveled *(had contact with resident populations)* for longer than one (1) week to a country at high risk for tuberculosis? ☐ YES ☐ NO

Has a family member or contact had tuberculosis or a positive tuberculin skins test? ☐ YES ☐ NO

Is your child infected with HIV? ☐ YES ☐ NO

DYSLIPIDEMIA

Does your child have parents or grandparents who have had a stroke or heart problem before age 55? ☐ YES ☐ NO

Does your child have a parent with elevated blood cholesterol *(240mg/dL or higher)* or who is taking cholesterol medication? ☐ YES ☐ NO

Additional comments:

_____

_____

Signature: _____ Date: _____ Relationship to Patient: _____

This screening form was adapted in part by the Ohio Medicaid managed care plans; Ohio Department of Jobs and Family Services, American Academy of Pediatrics, Bright Futures 2010.

BIRTH & BEYOND
PEDIATRICS P.C.

OKLAHOMA CHILDHOOD LEAD POISONING PREVENTION PROGRAM
2012 LEAD EXPOSURE RISK ASSESSMENT QUESTIONNAIRE (LERAQ)

Childs Name: _____ Date of Birth: _____ /_____ /_____

Date: _____ /_____ /_____ Age: _____ Current Residential Zip Code: _____

1. Does your child have Medicaid (SoonerCare)? If yes this child must have a blood lead test at 12 and 24 months of age (or, if older than 24 months, at least one test before 6th birthday).	Yes ☐	No ☐	Don't Know ☐
2. Does your child live in a high risk ZIP code area? (see a list of high risk ZIPs on this form)	Yes ☐	No ☐	Don't Know ☐
3. Does your child live in or often visit a house or child care site with chipped or peeling paint that was built prior to 1950?	Yes ☐	No ☐	Don't Know ☐
4. Does your child live in or often visit a house or child care site built prior to 1950 with renovation, repairs or remodeling that were done in the last 6 months?	Yes ☐	No ☐	Don't Know ☐
5. Does your child live in or often visit a house or child care site that has vinyl or plastic mini blinds?	Yes ☐	No ☐	Don't Know ☐
6. Does your child have friends, siblings, house mates, or a play mate that has or did have lead poisoning?	Yes ☐	No ☐	Don't Know ☐
7. Does your child live with an adult who has a job or hobby where lead is used? Examples would be: oil field worker, bridge painter, demolition or renovation of buildings, automobile work with batteries or radiators, lead solder, metal plating, furniture refinishing, leaded glass, lead shot or bullets and lead fishing sinkers.	Yes ☐	No ☐	Don't Know ☐
8. Is your child given any home or folk remedies or cosmetics such as imported items called Greta, Azarcon, Rudea, Kohl or does your child eat food cooked in or served from pottery made outside the United States?	Yes ☐	No ☐	Don't Know ☐
9. Does your child chew on or mouth trinket jewelry or toys found in vending machines?	Yes ☐	No ☐	Don't Know ☐

HIGH RISK ZIP CODES

☐ 73106	☐ 73108	☐ 73111	☐ 73119	☐ 73521	☐ 74104	☐ 74110	☐ 74127	☐ 74401	☐ 74447
☐ 73107	☐ 73109	☐ 73117	☐ 73129	☐ 73701	☐ 74106	☐ 74115	☐ 74354	☐ 74403	☐ 74631
									☐ 74848

Lead Poisoning Prevention Program
Screening and Special Services
Oklahoma State Department of Health
1000 NE 10th Street

Telephone: (405) 271-6617 Toll Free: 1-800-766-2223

Purpose: The LERAQ is to be used to screen for possible lead exposure in children 6 -72 months of age.
Use: This assessment may be administered by medical staff or teacher, or completed by the child's parent or guardian.
Any "Yes" or "don't know" answer is considered a positive answer thus requires the child to have a blood lead test.

According to OCLPPP Case Management Guidelines, if a child has a blood lead test <5 ug/dl, reassess with the LERAQ in 1 year. No additional testing is necessary unless an exposure risk change has occurred. This Guideline does not supersede the federal CMS requirement that children enrolled in SoonerCare receive a blood lead test at 12 and 24 months of age as defined in the Child Health Check Up, also known as Early and Periodic Screening; Diagnosis and Treatment (EPSDT). Routing and Filing: Retain this record in the child's record to review annually.

OSDH Form #386-Rev 06/2012

BIRTH & BEYOND
PEDIATRICS P.C.

ANEMIA RISK QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____ /_____ /_____

1. Has your child ever been diagnosed with iron deficiency anemia?

☐ Yes ☐ No

2. Do you ever have trouble getting food on the table?

☐ Yes ☐ No

3. If your child is under the age of 6 months, was your child born premature?

☐ Yes ☐ No

4. If your child is under the age of 6 months, did your child have a low birth weight?

☐ Yes ☐ No

5. Is your child on a strict vegetarian diet?

☐ Yes ☐ No

6. Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

☐ Yes ☐ No

7. If your child is under the age of 6 months, is your child drinking anything besides breastmilk or iron-fortified formula?

☐ Yes ☐ No

BIRTH & BEYOND
PEDIATRICS P.C.

M-CHAT

Date: _____ /_____ /_____

Patient Name: _____ Date of Birth: _____ /_____ /_____

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare *(e.g., you've seen it once or twice)*, please answer as if the child does not do it.

☐ **YES** ☐ **NO** 1. Does your child enjoy being swung, bounced on your knee, etc.?

☐ **YES** ☐ **NO** 2. Does your child take an interest in other children?

☐ **YES** ☐ **NO** 3. Does your child like climbing on things, such as up stairs?

☐ **YES** ☐ **NO** 4. Does your child enjoy playing peek-a-boo/hide-and-seek?

☐ **YES** ☐ **NO** 5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things?

☐ **YES** ☐ **NO** 6. Does your child ever use his/her index finger to point, to ask for something?

☐ **YES** ☐ **NO** 7. Does your child ever use his/her index finger to point, to indicate interest in something?

☐ **YES** ☐ **NO** 8. Can your child play properly with small toys *(e.g. cars or blocks)* without just mouthing, fiddling, or dropping them?

☐ **YES** ☐ **NO** 9. Does your child ever bring objects over to you *(parent)* to show you something?

☐ **YES** ☐ **NO** 10. Does your child look you in the eye for more than a second or two?

☐ **YES** ☐ **NO** 11. Does your child ever seem oversensitive to noise? *(e.g., plugging ears)*

☐ **YES** ☐ **NO** 12. Does your child smile in response to your face or your smile?

☐ **YES** ☐ **NO** 13. Does your child imitate you? *(e.g., you make a face-will your child imitate it?)*

☐ **YES** ☐ **NO** 14. Does your child respond to his/her name when you call?

☐ **YES** ☐ **NO** 15. If you point at a toy across the room, does your child look at it?

☐ **YES** ☐ **NO** 16. Does your child walk?

☐ **YES** ☐ **NO** 17. Does your child look at things you are looking at?

☐ **YES** ☐ **NO** 18. Does your child make unusual finger movements near his/her face?

☐ **YES** ☐ **NO** 19. Does your child try to attract your attention to his/her own activity?

☐ **YES** ☐ **NO** 20. Have you ever wondered if your child is deaf?

☐ **YES** ☐ **NO** 21. Does your child understand what people say?

☐ **YES** ☐ **NO** 22. Does your child sometimes stare at nothing or wander with no purpose?

☐ **YES** ☐ **NO** 23. Does your child look at your face to check your reaction when faced with something unfamiliar?