BIRTH & BEYOND PEDIATRICS P.C.

DEVELOPMENTAL SCREENING
7&8 YEARS

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 Gets along with family

☐ YES ☐ NO Does chores when asked

☐ YES ☐ NO Is vigorously active for 1 hour a day

☐ YES ☐ NO Spends less than 2 hours per day watching TV, playing video games or using the computer *(other than for schoolwork)*

☐ YES ☐ NO Eats healthy meals and snacks

☐ YES ☐ NO Eats at least 5 servings of fruits and vegetables a day

☐ YES ☐ NO Eats breakfast regularly

☐ YES ☐ NO Has friends

☐ YES ☐ NO Is doing well in school

☐ YES ☐ NO Participates in an after-school activity

☐ YES ☐ NO Knows how to swim and only swims when an adult is watching

☐ YES ☐ NO Lives in a smoke free home and rides in smoke free automobiles

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

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

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____ /_____ /_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Check boxes to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL**: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult