SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

0-2 Week

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in.
Temp _____ Pulse _____ Resp _____ Head Circ _____ Pain Score (0 – 5) _____
❑ Environmental Screen ❑ Lead Risk Assessment ❑ Growth chart plotted
Birth History_____ ❑ Term ❑ Preterm Weeks _____
Birth Wt. _____ Discharge Wt. _____ Discharge Date _____
Blood type: ❑ Mom _____ Rh _____ Baby _____ Rh _____ Coombs _____
Apgar _____ Hearing Screen ❑ Pass ❑ Referral
Metabolic Screen obtained 48 hours of age? ❑ Yes ❑ No ❑ WNL Copy of results in chart ❑ Yes ❑ No ❑ Requested copy
Received HepB in hospital? ❑ Yes ❑ No Date:_____
Nutrition: ❑ Breast ❑ Formula Type _____ ❑ Vitamin D
Adverse Reactions (drug allergies): ❑ Yes* _____ ❑ No *If yes, also list on Patient Problem Summary in front of chart.
❑ Parent section reviewed? ❑ Parent's concerns addressed
Problems: _____

CURRENT MEDICATIONS: ❑None or list medications below.

NAME	DOSE	FREQUENCY

Nurse's Signature
X

PHYSICAL: Check (☑) if normal. Circle if abnormal and describe.
❑ General Appearance
❑ Head/Face/Neck
❑ Eyes ❑ Red Reflex
❑ ENMT
❑ Respiratory
❑ Chest
❑ CV
❑ Abdomen
❑ Genitalia
❑ Skin
❑ Lymph nodes
❑ Extremities ❑ Hips
❑ Musculoskeletal
❑ Back
❑ Neuro

ANTICIPATORY GUIDANCE: ❑ Sleep ❑ Car Safety ❑ Nutrition ❑ Immunization Information ❑ TIPP
❑ Medication Education (if applicable)

ASSESSMENT: _____

PLAN: _____
❑ Interpretive conference conducted; Return _____
❑ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS**_____
❑ Parent/guardian verbalized understanding the **Plan of Care. INITIALS** _____

Physician/Practitioner's Signature **X**	**Date** / /	**Time** AM/PM :

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PATIENT DATA

Parent Section
0-2 Week

SECTION TO BE COMPLETED BY PARENT

Personal/Social History
Are you <u>CONCERNED</u> about your child's…
(check appropriate box for each question)

	Yes	No
1. Feedings?	❑	❑
2. Excessive spitting or vomiting?	❑	❑
3. Nasal stuffiness?	❑	❑
4. Skin color or skin rashes (circle one)?	❑	❑
5. Excessive crying?	❑	❑
6. Sleep habits?	❑	❑
7. Does your child sleep on their back?	❑	❑
8. Does your child ride in a rear-facing safety seat?	❑	❑

Parent Section
❑ Mother ❑ Father ❑ Other _____

9. Are you getting enough rest?	❑	❑
10. Have you been sad, depressed, crying a lot?	❑	❑

Environmental Screening
Does your child….

	Yes	No
11. Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)?	❑	❑
12. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)?	❑	❑
13. Have a sibling or playmate who now has or did have lead poisoning?	❑	❑
14. Does anyone smoke in the household?	❑	❑
15. Do you have a swimming pool?	❑	❑

Parent Comments (Please Print)	Yes	No
16. Do you have any concerns you wish to discuss?	❑	❑

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: