Recommendations for Comprehensive Pediatric Health Assessment

	INFANCY							EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE	NB	3-5 d	1 m	2 m	4 m	6 m	9 m	12 m	15 m	18 m	24 m	30 m	3y	4y	5y	6y	7y	8y	9y	10y	11y	12y	13y	14y	15y	16y	17y	18y	19y	20y	21y
FORMAT/DOCUMENTATION																															
Biographical Info	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Emergency Contact	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Assigned PCP	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Primary Language	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Medical Interpreter	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Signed Notice of Privacy	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Allergies	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Chronic Problems	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Continuous Medications	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Advanced Healthcare Directive																												●	●	●	●
HISTORY																															
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height & Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length	●	●	●	●	●	●	●	●	●	●	●																				
Body Mass Index (BMI)											●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure													●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision								○			○		●	●	●	●		●		●		●			●						
Hearing	⟷	⟷	⟷	⟷										●	●			●		●	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷
DEVELOPMENT/SOCIAL/MENTAL																															
Maternal Depression			●	●	●	●																									
Developmental Disorder							●			●		●																			
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Autism Spectrum Disorder										●	●																				
Psychosocial/Behavioral	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol, Drug, Tobacco Use																					●	●	●	●	●	●	●	●	●	●	●
Depression																						●	●	●	●	●	●	●	●	●	●
Suicide Risk																						●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAM	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEMBER RISK ASSESSMENT	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES																															
Anemia					●			☒	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Immunization	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Lead								☒			☒																				
Tuberculosis			●			●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Dyslipidemia											●			●		●		●	⟷	⟷							⟷	⟷	⟷	⟷	⟷
Sexually Transmitted Infections																					●	●	●	●	●	●	●	●	●	●	●
HIV																					●	●	●	●	●	●	●	●	●	●	●
Hepatitis B Virus Infection	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hepatitis C Virus Infection																												●	●	●	●
Sudden Cardiac Arrest/Death																					⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷
ORAL HEALTH																															
Fluoride Varnish						⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷																
Fluoride Supplementation						⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷	⟷																

● – Required ○ – If applicable ⟷ – age range for assessment ☒ – lab test *This document is a quick guide. Please refer to DHCS standards for details.*

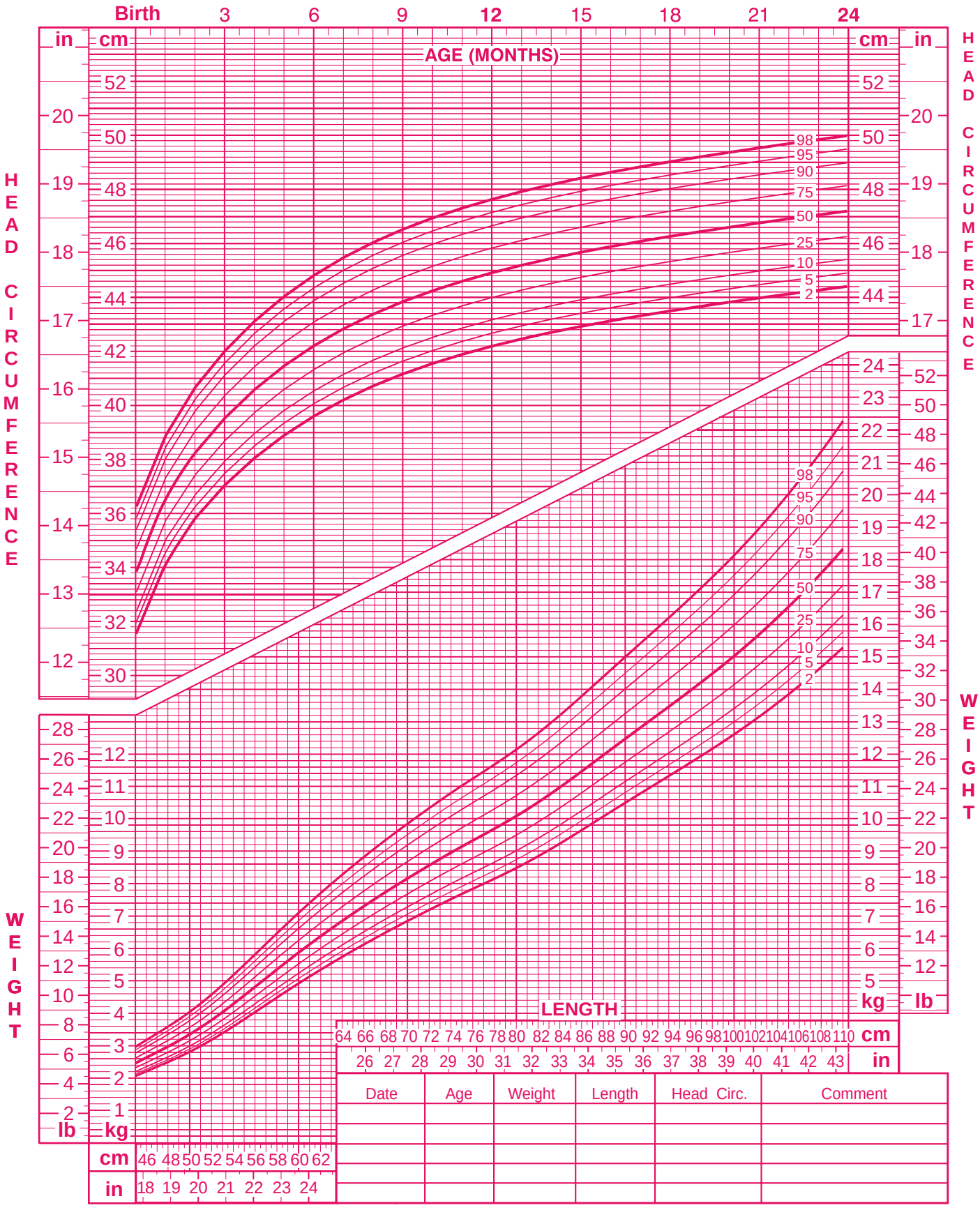
Recommended and/or Required Screening Tools

(Check bookmarks or click page number to jump to page)

Birth to 24 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

NAME _____

RECORD # _____

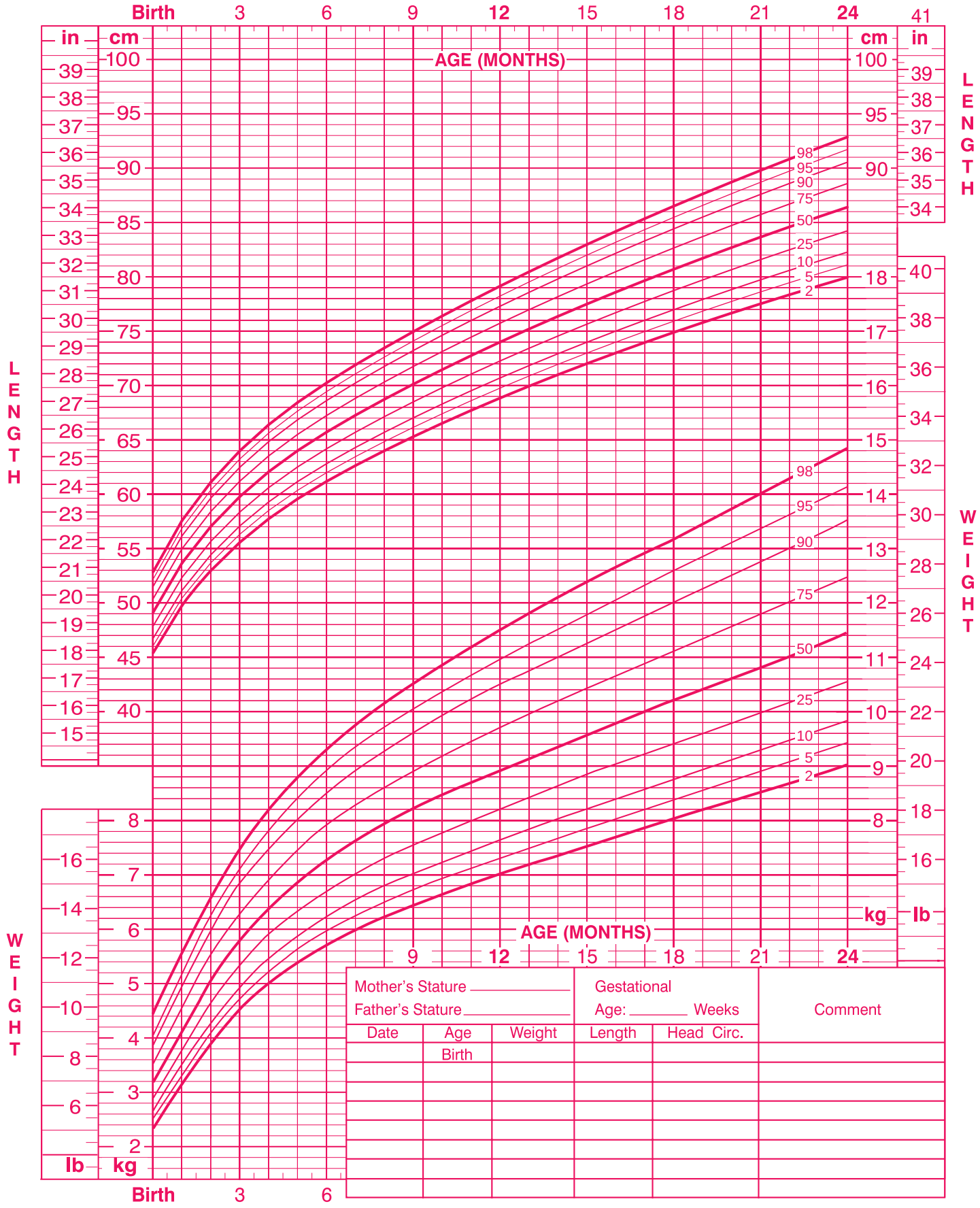


Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD # _____



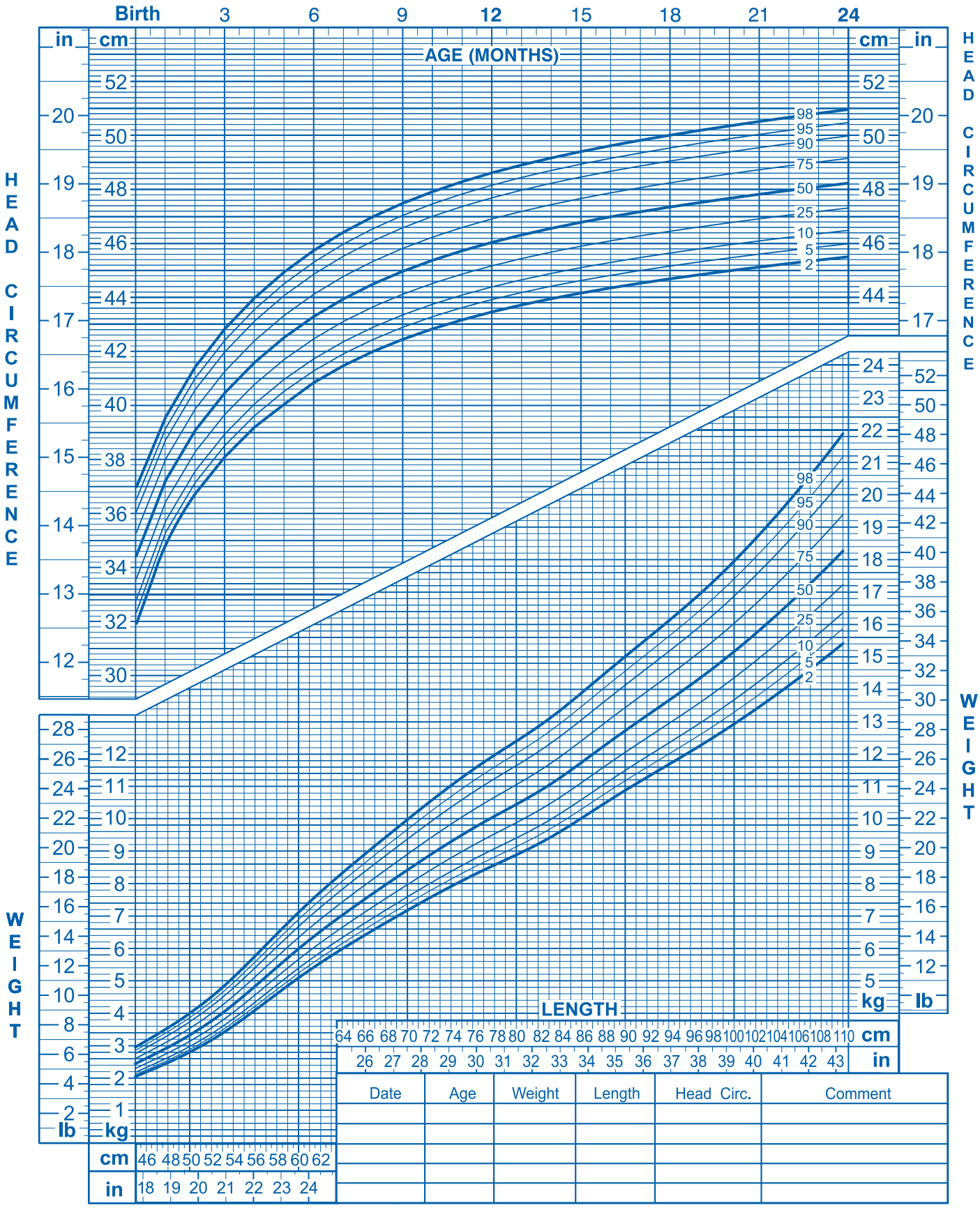
Mother's Stature _____			Gestational Age: _____ Weeks		Comment
Father's Stature _____					
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Boys
Head circumference-for-age and Weight-for-length percentiles

NAME _____

RECORD # _____



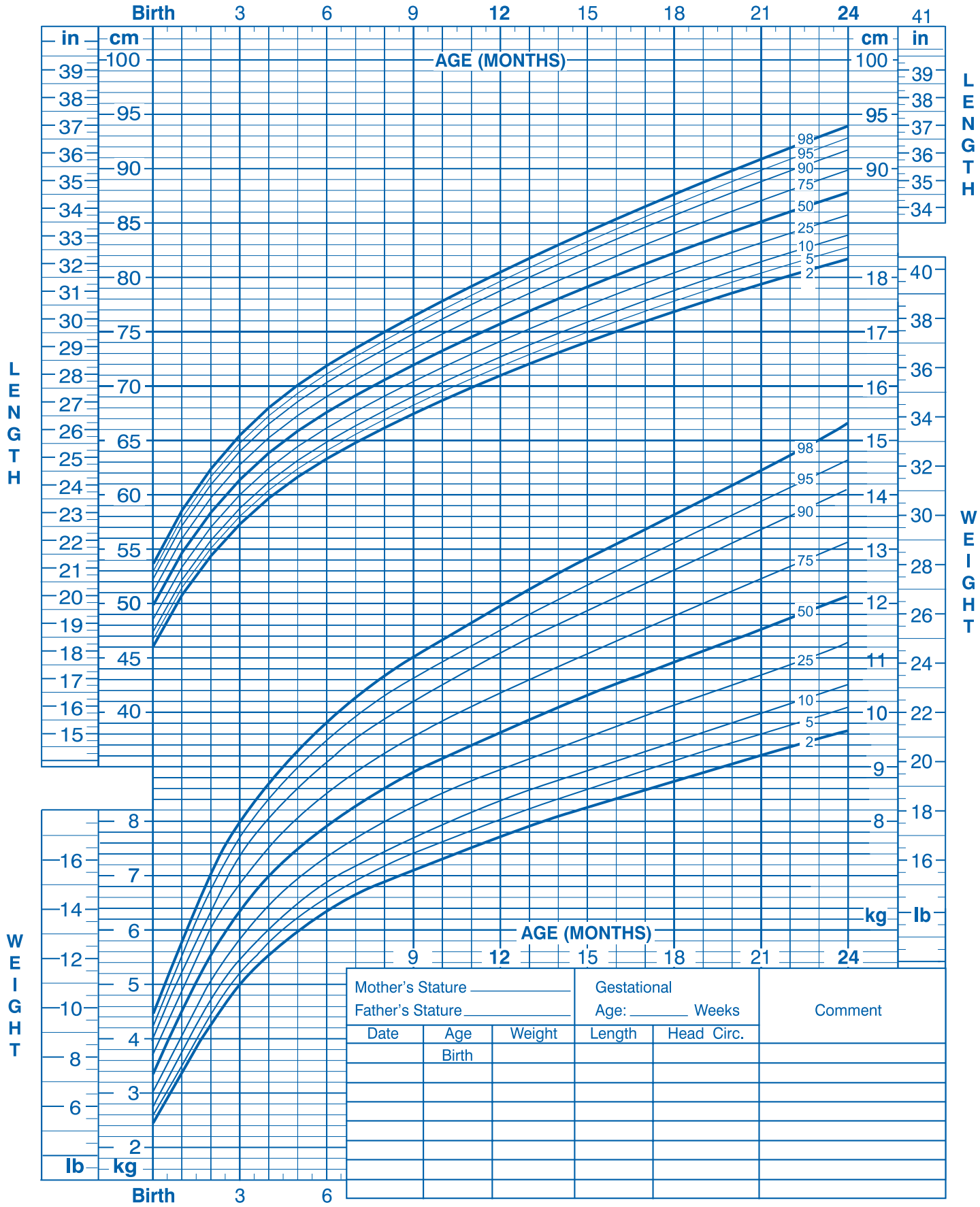
Date	Age	Weight	Length	Head Circ.	Comment

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

Birth to 24 months: Boys
Length-for-age and Weight-for-age percentiles

NAME _____

RECORD #



Mother's Stature _____			Gestational		
Father's Stature _____			Age: _____ Weeks		Comment
Date	Age	Weight	Length	Head Circ.	
	Birth				

Published by the Centers for Disease Control and Prevention, November 1, 2009
SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)

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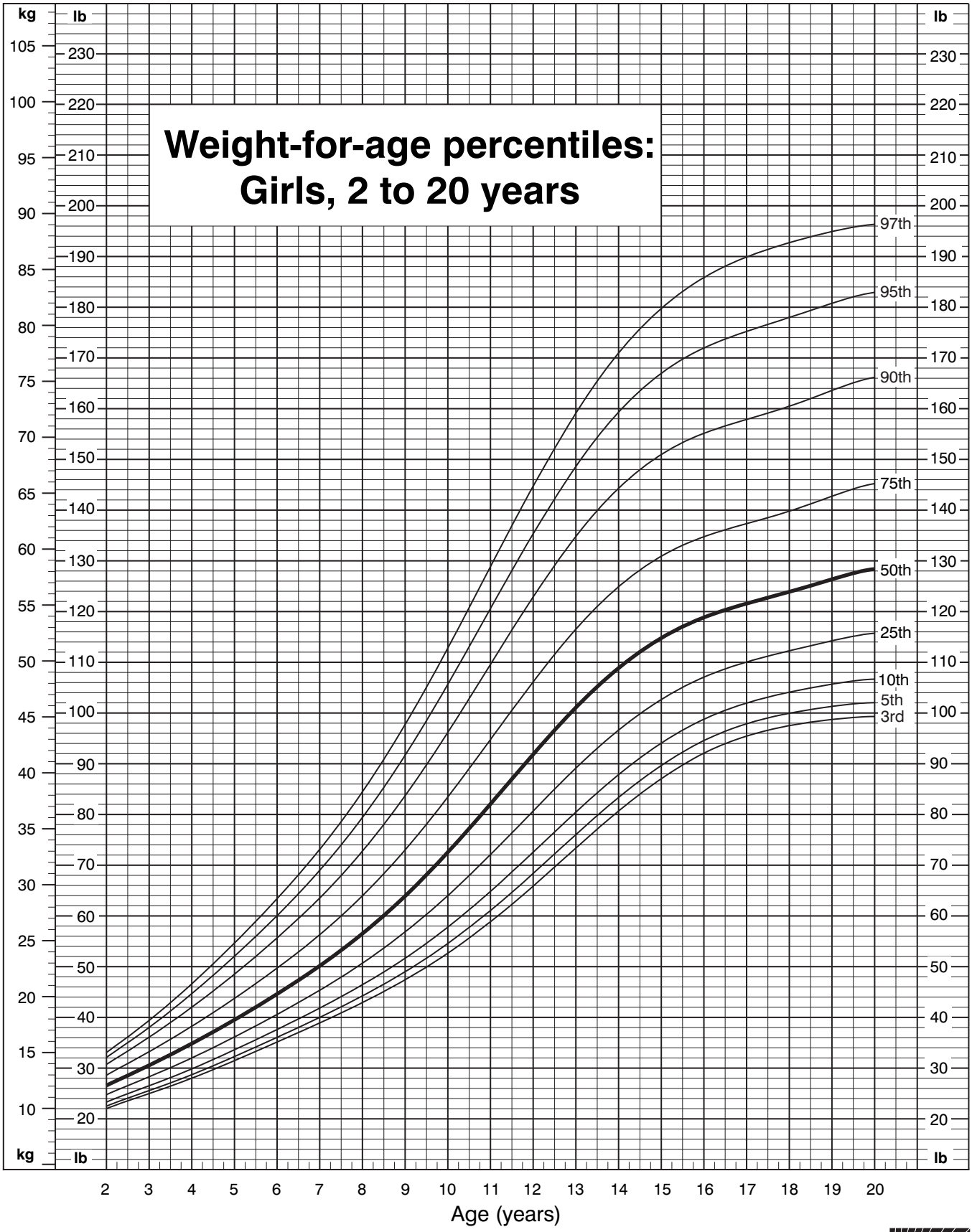
CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

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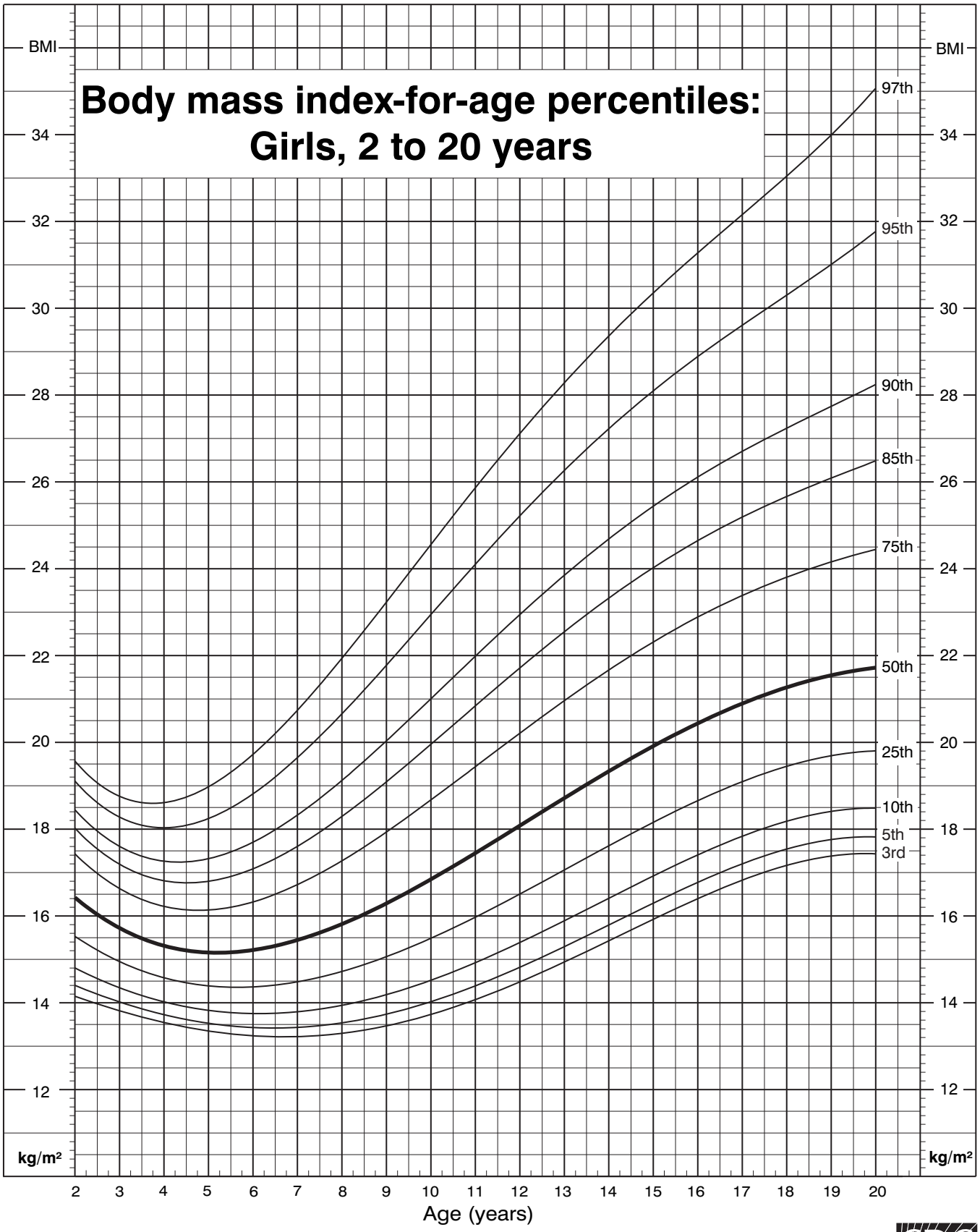
CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

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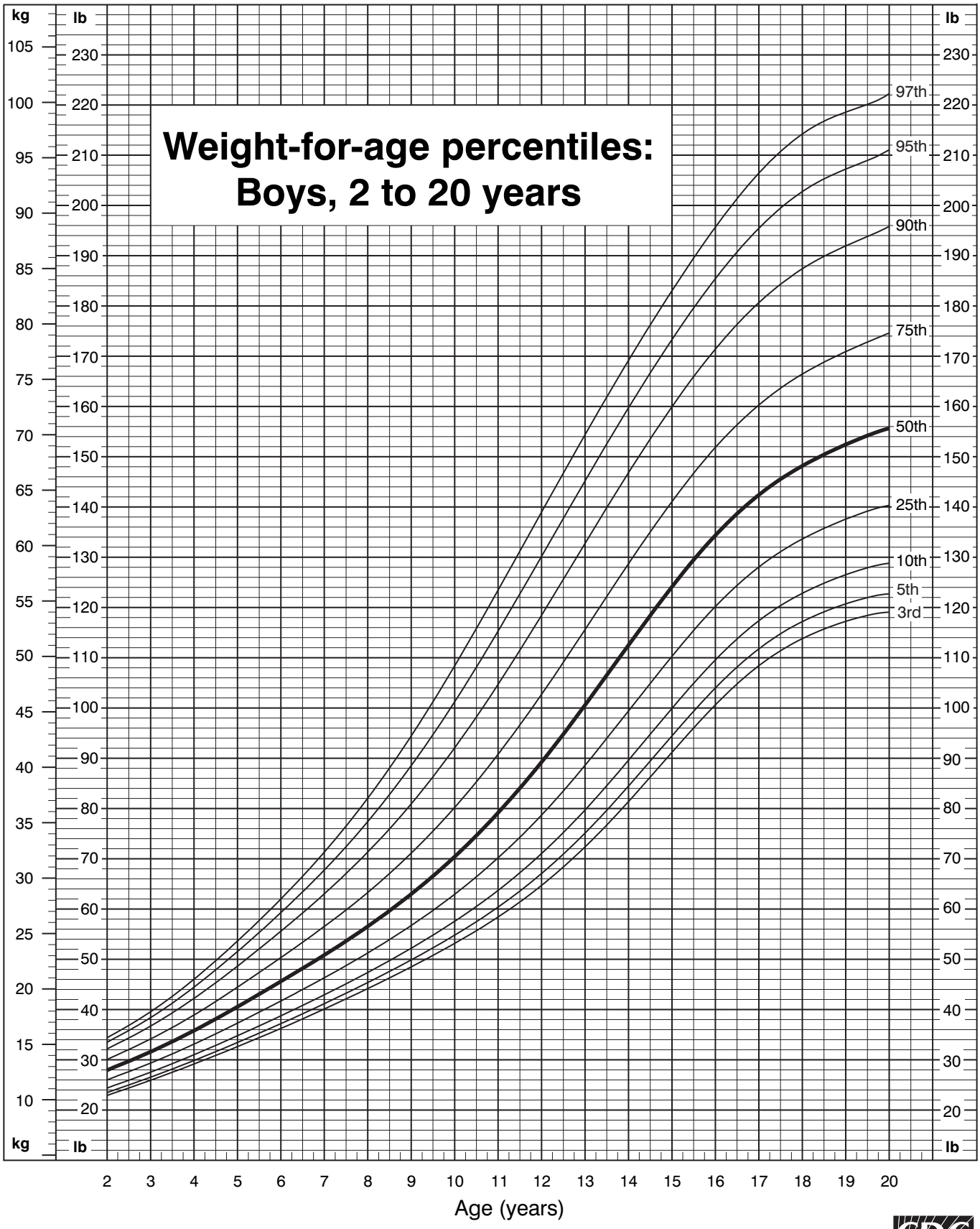
CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

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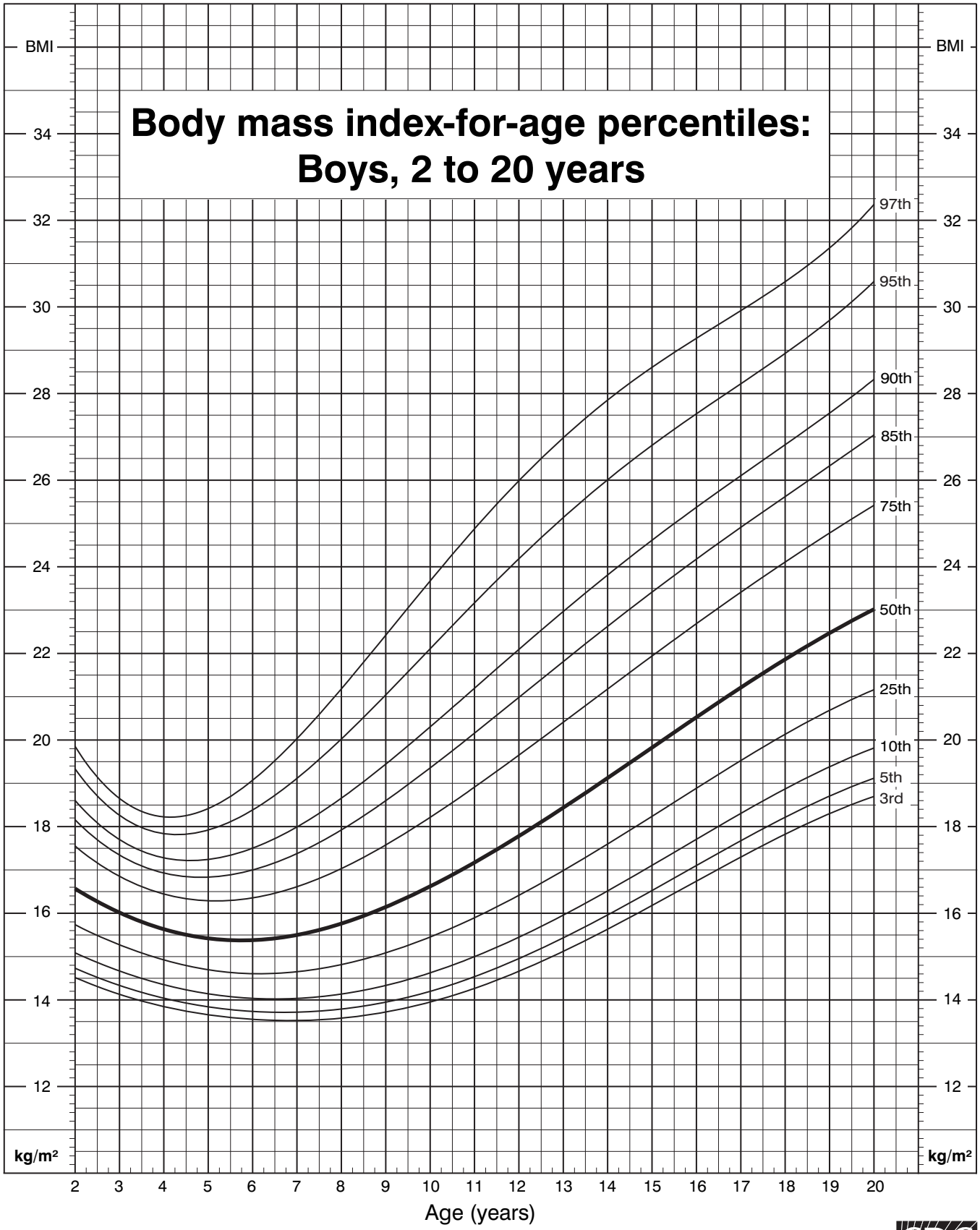
CDC Growth Charts: United States



Published May 30, 2000.

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

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SAMPLE

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last2weeks, how often have you been bothered by any of the following problems? *(Use " = " 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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
⑤	⑤	⑤	⑤

Edinburgh Postnatal Depression Scale (EPDS)

Date: _____ Clinic Name/Number: _____

Your Age: _____ Weeks of Pregnancy/Age of Baby: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶ _____

*** If you scored a 1, 2 or 3 on question 10, PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

If your total score is 11 or more, you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

If your total score is 9-10, we suggest you **repeat this test in one week or call your health care provider** (OB/Gyn, family doctor or nurse-midwife).

If your total score is 1-8, new mothers often have mood swings that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- ▶ Getting sleep—nap when the baby naps.
- ▶ Asking friends and family for help.
- ▶ Drinking plenty of fluids.
- ▶ Eating a good diet.
- ▶ Getting exercise, even if it's just walking outside.

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

See more information on reverse. ▶

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Nombre de participante:_____ Número de identificación de participante: _____

Fecha:_____

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:

Sí, todo el tiempo	____ 0
Sí, la mayor parte del tiempo	✔ 1
No, no muy a menudo	____ 2
No, en absoluto	____ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:
   - Tanto como siempre he podido hacerlo ____ 0
   - No tanto ahora ____ 1
   - Sin duda, mucho menos ahora ____ 2
   - No, en absoluto ____ 3

2. He mirado al futuro con placer para hacer cosas:
   - Tanto como siempre ____ 0
   - Algo menos de lo que solía hacerlo ____ 1
   - Definitivamente menos de lo que solía hacerlo ____ 2
   - Prácticamente nunca ____ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   - Sí, casi siempre ____ 3
   - Sí, algunas veces ____ 2
   - No muy a menudo ____ 1
   - No, nunca ____ 0

4. He estado ansiosa y preocupada sin motivo alguno:
   - No, en absoluto ____ 0
   - Casi nada ____ 1
   - Sí, a veces ____ 2
   - Sí, muy a menudo ____ 3

5. He sentido miedo o pánico sin motivo alguno:
   - Sí, bastante ____ 3
   - Sí, a veces ____ 2
   - No, no mucho ____ 1
   - No, en absoluto ____ 0

6. Las cosas me oprimen o agobian:
   - Sí, la mayor parte del tiempo no he podido sobrellevarlas ____ 3
   - Sí, a veces no he podido sobrellevarlas de la manera ____ 2
   - No, la mayoría de las veces he podido sobrellevarlas bastante bien ____ 1
   - No, he podido sobrellevarlas tan bien como lo hecho siempre ____ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   - Sí, casi siempre ____ 3
   - Sí, a veces ____ 2
   - No muy a menudo ____ 1
   - No, en absoluto ____ 0

8. Me he sentido triste y desgraciada:
   - Sí, casi siempre ____ 3
   - Sí, bastante a menudo ____ 2
   - No muy a menudo ____ 1
   - No, en absoluto ____ 0

9. Me he sentido tan infeliz que he estado llorando:
   - Sí, casi siempre ____ 3
   - Sí, bastante a menudo ____ 2
   - Ocasionalmente ____ 1
   - No, nunca ____ 0

10. He pensado en hacerme daño:
    - Sí, bastante a menudo ____ 3
    - A veces ____ 2
    - Casi nunca ____ 1
    - No, nunca ____ 0

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry,* Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long term effects on the family.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the "blues" (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

ASQ-3 Ages & Stages Questionnaires®

9 months 0 days through 9 months 30 days

9 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Baby's information

Baby's first name: | Middle initial: | Baby's last name:

Baby's date of birth: M M D D Y Y Y Y

If baby was born 3 or more weeks prematurely, # of weeks premature:

Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name: | Middle initial: | Last name:

Street address:

Relationship to baby: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City: | State/Province: | ZIP/Postal code:

Country: | Home telephone number: | Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Baby ID #:

Program ID #:

Program name:

Age at administration, in months and days: M M D D

If premature, adjusted age, in months and days: M M D D

ASQ-3™

9 Month Questionnaire

9 months 0 days through 9 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	◯	◯	◯	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	◯	◯	◯	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	◯	◯	◯	___
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	◯	◯	◯	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	◯	◯	◯	___
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? *(A "word" is a sound or sounds your baby says consistently to mean someone or something.)*	◯	◯	◯	___
			COMMUNICATION TOTAL	___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing? 	◯	◯	◯	___
2. When sitting on the floor, does your baby sit up straight for several minutes *without* using his hands for support? 	◯	◯	◯	___

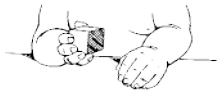
E101090201

GROSS MOTOR *(continued)*

	YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support? 	◯	◯	◯	___
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position? 	◯	◯	◯	___
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	◯	◯	◯	___
6. Does your baby walk beside furniture while holding on with only one hand?	◯	◯	◯	___

GROSS MOTOR TOTAL ___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand? 	◯	◯	◯	___
2. Does your baby *successfully* pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? *(If she already picks up a crumb or Cheerio, mark "yes" for this item.)* 	◯	◯	◯	___
3. Does your baby pick up a small toy with the *tips* of his thumb and fingers? *(You should see a space between the toy and his palm.)* 	◯	◯	◯	___
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? *(The string may be attached to a toy.)* 	◯	◯	◯	___
5. Does your baby pick up a crumb or Cheerio with the *tips* of his thumb and a finger? He may rest his arm or hand on the table while doing it. 	◯	◯	◯	___ *
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	◯	◯	◯	___

FINE MOTOR TOTAL ___

**If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby pass a toy back and forth from one hand to the other? 	◯	◯	◯	___
2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute? 	◯	◯	◯	___
3. When holding a toy in his hand, does your baby bang it against another toy on the table? 	◯	◯	◯	___
4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	◯	◯	◯	___
5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	◯	◯	◯	___
6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? *(Be sure the toy is completely hidden.)*	◯	◯	◯	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While your baby is on her back, does she put her foot in her mouth? 	◯	◯	◯	___
2. Does your baby drink water, juice, or formula from a cup while you hold it?	◯	◯	◯	___
3. Does your baby feed himself a cracker or a cookie?	◯	◯	◯	___
4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? *(If she already lets go of the toy into your hand, mark "yes" for this item.)*	◯	◯	◯	___
5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?	◯	◯	◯	___
6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?	◯	◯	◯	___
		PERSONAL-SOCIAL TOTAL		___

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain: ◯ YES ◯ NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: ◯ YES ◯ NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: ◯ YES ◯ NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

5. Do you have concerns about your baby's vision? If yes, explain: ◯ YES ◯ NO

6. Has your baby had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

OVERALL *(continued)*

7. Do you have any concerns about your baby's behavior? If yes, explain: ◯ YES ◯ NO

8. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

9 Month ASQ-3 Information Summary

9 months 0 days through 9 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.97		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	17.82		●	●	●	●	○	○	○	○	○	○	○	○	○
Fine Motor	31.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	28.72		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	18.91		●	●	●	●	○	○	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Uses both hands and both legs equally well? Yes **NO**
   Comments:

2. Feet are flat on the surface most of the time? Yes **NO**
   Comments:

3. Concerns about not making sounds? **YES** No
   Comments:

4. Family history of hearing impairment? **YES** No
   Comments:

5. Concerns about vision? **YES** No
   Comments:

6. Any medical problems? **YES** No
   Comments:

7. Concerns about behavior? **YES** No
   Comments:

8. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101090701

ASQ-3 Ages & Stages Questionnaires®

17 months 0 days through 18 months 30 days

18 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

If child was born 3 or more weeks prematurely, # of weeks premature:

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Age at administration, in months and days: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:

E101180100

18 Month Questionnaire

17 months 0 days through 18 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

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, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by *pointing* to it?	◯	◯	◯	___
2. When you ask your child to, does he 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? *(Mark "yes" even if her words are difficult to understand.)*	◯	◯	◯	___
5. Without your showing him, 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 ___

E101180200

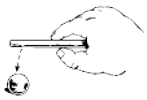
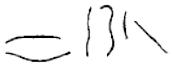
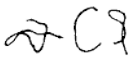
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
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 (for example, to get a toy on a counter or to "help" you in the kitchen)?	◯	◯	◯	___
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	◯	◯	◯	___
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	◯	◯	◯	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "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 himself?	◯	◯	◯	___
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

	YES	SOMETIMES	NOT YET	
1. Does your child drop several small toys, one after another, into a container like a bowl or box? *(You may show him how to do it.)*	◯	◯	◯	___
2. After you have shown your child how, does she 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 turn the bottle over to dump it out? *(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)*	◯	◯	◯	___
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	◯	◯	◯	___
5. After watching 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*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "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 him how.)*	◯	◯	◯	___ *

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While looking at herself in the mirror, does your child offer a toy to her 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 he 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 below for additional comments.

1. Do you think your child hears well? If no, explain: ◯ YES ◯ NO

2. Do you think your child talks like other toddlers his age? If no, explain: ◯ YES ◯ NO

3. Can you understand most of what your child says? If no, explain: ◯ YES ◯ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain: ◯ YES ◯ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

6. Do you have concerns about your child's vision? If yes, explain: ◯ YES ◯ NO

E101180500

OVERALL *(continued)*

7. Has your child had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

8. Do you have any concerns about your child's behavior? If yes, explain: ◯ YES ◯ NO

9. Does anything about your child worry you? If yes, explain: ◯ YES ◯ NO

18 Month ASQ-3 Information Summary

17 months 0 days through 18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	●	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101180700

ASQ-3 Ages & Stages Questionnaires®

28 months 16 days through 31 months 15 days

30 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Program ID #:

Program name:

E101300100

30 Month Questionnaire

28 months 16 days through 31 months 15 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	◯	◯	◯	___
2. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	◯	◯	◯	___
◯ a. "Put the toy on the table." ◯ d. "Find your coat."				
◯ b. "Close the door." ◯ e. "Take my hand."				
◯ c. "Bring me a towel." ◯ f. "Get your book."				
3. When you ask your child to point to her nose, eyes, hair, feet, ears, and so forth, does she correctly point to at least *seven* body parts? *(She can point to parts of herself, you, or a doll. Mark "sometimes" if she correctly points to at least three different body parts.)*	◯	◯	◯	___
4. Does your child make sentences that are three or four words long? Please give an example:	◯	◯	◯	___
5. Without giving your child help by pointing or using gestures, ask him to "put the book *on* the table" and "put the shoe *under* the chair." Does your child carry out both of these directions correctly?	◯	◯	◯	___
6. When looking at a picture book, does your child tell you what is happening or what action is taking place in the picture (for example, "barking," "running," "eating," or "crying")? You may ask, "What is the dog (or boy) doing?"	◯	◯	◯	___

COMMUNICATION TOTAL ___

E101300200

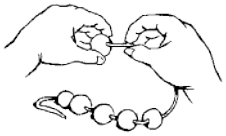
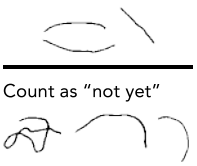
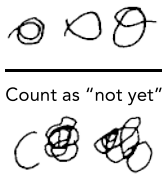
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	___
2. Does your child walk either up or down at least two steps by himself? He may hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)* 	○	○	○	___
3. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	___
4. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	___
5. Does your child walk up stairs, using only one foot on each stair? *(The left foot is on one step, and the right foot is on the next.)* She may hold onto the railing or wall. 	○	○	○	___ *
6. Does your child stand on one foot for about 1 second without holding onto anything? 	○	○	○	___

GROSS MOTOR TOTAL ___

**If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

FINE MOTOR

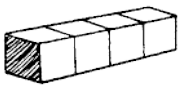
	YES	SOMETIMES	NOT YET	
1. Does your child use a turning motion with her hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	◯	◯	◯	___
2. After your child watches you draw a line from the top of the paper to the bottom with a pencil, crayon, or pen, ask him to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a vertical direction? 	◯	◯	◯	___
3. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	◯	◯	◯	___
4. After your child watches you draw a line from one side of the paper to the other side, ask her to make a line like yours. Do not let your child trace your line. Does your child copy you by drawing a single line in a horizontal direction? 	◯	◯	◯	___
5. After your child watches you draw a single circle, ask him to make a circle like yours. Do not let him trace your circle. Does your child copy you by drawing a circle? 	◯	◯	◯	___
6. Does your child turn pages in a book, one page at a time?	◯	◯	◯	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When looking in the mirror, ask, "Where is _____?" *(Use your child's name.)* Does your child point to her image in the mirror? 	◯	◯	◯	___
2. If your child wants something he cannot reach, does he find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	◯	◯	◯	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
3. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	◯	◯	◯	___
4. When you point to the figure and ask your child, "What is this?" does your child say a word that means a person or something similar? *(Mark "yes" for responses like "snowman," "boy," "man," "girl," "Daddy," "spaceman," and "monkey.")* Please write your child's response here: 	◯	◯	◯	___
5. When you say, "Say 'seven three,'" does your child repeat *just* the two numbers in the same order? *Do not repeat the numbers.* If necessary, try another pair of numbers and say, "Say 'eight two.'" Your child must repeat just one series of two numbers for you to answer "yes" to this question.	◯	◯	◯	___
6. After your child draws a "picture," even a simple scribble, does she tell you what she drew? *(You may say, "Tell me about your picture," or ask, "What is this?" to prompt her.)*	◯	◯	◯	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. If you do any of the following gestures, does your child copy at least one of them?	◯	◯	◯	___
◯ a. Open and close your mouth. ◯ c. Pull on your earlobe.				
◯ b. Blink your eyes. ◯ d. Pat your cheek.				
2. Does your child use a spoon to feed himself with little spilling?	◯	◯	◯	___
3. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if she cannot turn?	◯	◯	◯	___
4. Does your child put on a coat, jacket, or shirt by himself?	◯	◯	◯	___
5. After you put on loose-fitting pants around her feet, does your child pull them completely up to her waist?	◯	◯	◯	___
6. When your child is looking in a mirror and you ask, "Who is in the mirror?" does he say either "me" or his own name?	◯	◯	◯	___
		PERSONAL-SOCIAL TOTAL		___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ◯ YES ◯ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ◯ YES ◯ NO

3. Can you understand most of what your child says? If no, explain: ◯ YES ◯ NO

4. Can other people understand most of what your child says? If no, explain: ◯ YES ◯ NO

5. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ◯ YES ◯ NO

6. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

OVERALL *(continued)*

7. Do you have any concerns about your child's vision? If yes, explain: ◯ YES ◯ NO

8. Has your child had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

9. Do you have any concerns about your child's behavior? If yes, explain: ◯ YES ◯ NO

10. Does anything about your child worry you? If yes, explain: ◯ YES ◯ NO

30 Month ASQ-3 Information Summary

28 months 16 days through 31 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	33.30		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	36.14		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	19.25		●	●	●	●	○	○	○	○	○	○	○	○	○
Problem Solving	27.08		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	32.01		●	●	●	●	●	●	●	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Others understand most of what your child says? Yes **NO**
   Comments:
5. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
6. Family history of hearing impairment? **YES** No
   Comments:
7. Concerns about vision? **YES** No
   Comments:
8. Any medical problems? **YES** No
   Comments:
9. Concerns about behavior? **YES** No
   Comments:
10. Other concerns? **YES** No
    Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101300800

ASQ-3 Ages & Stages Questionnaires®

17 months 0 days through 18 months 30 days

18 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

If child was born 3 or more weeks prematurely, # of weeks premature:

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Age at administration, in months and days: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:

E101180100

18 Month Questionnaire

17 months 0 days through 18 months 30 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

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, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by *pointing* to it?	◯	◯	◯	___
2. When you ask your child to, does he 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? *(Mark "yes" even if her words are difficult to understand.)*	◯	◯	◯	___
5. Without your showing him, 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 ___

E101180200

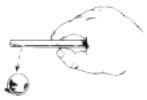
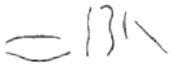
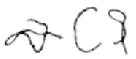
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
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 (for example, to get a toy on a counter or to "help" you in the kitchen)?	◯	◯	◯	___
5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	◯	◯	◯	___
6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	◯	◯	◯	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "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 himself?	◯	◯	◯	___
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

	YES	SOMETIMES	NOT YET	
1. Does your child drop several small toys, one after another, into a container like a bowl or box? *(You may show him how to do it.)*	◯	◯	◯	___
2. After you have shown your child how, does she 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 turn the bottle over to dump it out? *(You may show him how.) (You can use a soda-pop bottle or a baby bottle.)*	◯	◯	◯	___
4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?	◯	◯	◯	___
5. After watching 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*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "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 him how.)*	◯	◯	◯	___ *

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. While looking at herself in the mirror, does your child offer a toy to her 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 he 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 below for additional comments.

1. Do you think your child hears well? If no, explain: ◯ YES ◯ NO

2. Do you think your child talks like other toddlers his age? If no, explain: ◯ YES ◯ NO

3. Can you understand most of what your child says? If no, explain: ◯ YES ◯ NO

4. Do you think your child walks, runs, and climbs like other toddlers her age? If no, explain: ◯ YES ◯ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

6. Do you have concerns about your child's vision? If yes, explain: ◯ YES ◯ NO

E101180500

OVERALL *(continued)*

7. Has your child had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

8. Do you have any concerns about your child's behavior? If yes, explain: ◯ YES ◯ NO

9. Does anything about your child worry you? If yes, explain: ◯ YES ◯ NO

18 Month ASQ-3 Information Summary

17 months 0 days through 18 months 30 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	●	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	●	○	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101180700

ASQ-3 Ages & Stages Questionnaires®

23 months 0 days through 25 months 15 days

24 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Program ID #:

Program name:

E101240100

24 Month Questionnaire

23 months 0 days through 25 months 15 days

On the following pages are questions about activities children may 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 fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your child before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your child.
- ☑ Make sure your child is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

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, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(She needs to identify only one picture correctly.)*	◯	◯	◯	___
2. 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? *(Mark "yes" even if her words are difficult to understand.)*	◯	◯	◯	___
3. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	◯	◯	◯	___

◯ a. "Put the toy on the table." ◯ d. "Find your coat."

◯ b. "Close the door." ◯ e. "Take my hand."

◯ c. "Bring me a towel." ◯ f. "Get your book."

4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	◯	◯	◯	___
5. 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:	◯	◯	◯	___

E101240200

COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	◯	◯	◯	___

COMMUNICATION TOTAL ___

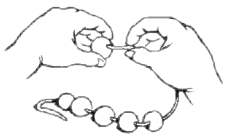
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. *(You can look for this at a store, on a playground, or at home.)*	◯	◯	◯	___
2. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? *(If your child already kicks a ball, mark "yes" for this item.)* 	◯	◯	◯	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall. 	◯	◯	◯	___
4. Does your child run fairly well, stopping herself without bumping into things or falling? 	◯	◯	◯	___
5. Does your child jump with both feet leaving the floor at the same time? 	◯	◯	◯	___
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	◯	◯	◯	___ *

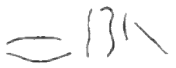
GROSS MOTOR TOTAL ___

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

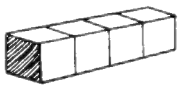
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	◯	◯	◯	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	◯	◯	◯	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	◯	◯	◯	___
4. Does your child flip switches off and on?	◯	◯	◯	___
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	◯	◯	◯	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	◯	◯	◯	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. After watching 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*? *(Mark "not yet" if your child scribbles back and forth.)* Count as "yes"  Count as "not yet" 	◯	◯	◯	___
2. 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 him how.) (You can use a soda-pop bottle or baby bottle.)*	◯	◯	◯	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	◯	◯	◯	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	◯	◯	◯	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	◯	◯	◯	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	◯	◯	◯	___
			PROBLEM SOLVING TOTAL	___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	◯	◯	◯	___
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	◯	◯	◯	___
3. Does your child eat with a fork?	◯	◯	◯	___
4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	◯	◯	◯	___
5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	◯	◯	◯	___
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."	◯	◯	◯	___
			PERSONAL-SOCIAL TOTAL	___

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain: ◯ YES ◯ NO

2. Do you think your child talks like other toddlers her age? If no, explain: ◯ YES ◯ NO

E101240500

OVERALL *(continued)*

3. Can you understand most of what your child says? If no, explain: ◯ YES ◯ NO

4. Do you think your child walks, runs, and climbs like other toddlers his age? If no, explain: ◯ YES ◯ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

6. Do you have any concerns about your child's vision? If yes, explain: ◯ YES ◯ NO

7. Has your child had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

OVERALL *(continued)*

8. Do you have any concerns about your child's behavior? If yes, explain: ◯ YES ◯ NO

9. Does anything about your child worry you? If yes, explain: ◯ YES ◯ NO

24 Month ASQ-3 Information Summary

23 months 0 days through 25 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Hears well? Yes **NO**
   Comments:
2. Talks like other toddlers his age? Yes **NO**
   Comments:
3. Understand most of what your child says? Yes **NO**
   Comments:
4. Walks, runs, and climbs like other toddlers? Yes **NO**
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the child's total score is in the ▭ area, it is above the cutoff, and the child's development appears to be on schedule.
If the child's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the child's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

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CSBS DP Infant-Toddler Checklist

Child's name: _____ *Date of birth:* _____ *Date filled out:* _____

Was birth premature? _____ *If yes, how many weeks premature?* _____

Filled out by: _____ *Relationship to child:* _____

Instructions for caregivers: This Checklist is designed to identify different aspects of development in infants and toddlers. Many behaviors that develop before children talk may indicate whether or not a child will have difficulty learning to talk. This Checklist should be completed by a caregiver when the child is between **6 and 24 months of age** to determine whether a referral for an evaluation is needed. The caregiver may be either a parent or another person who nurtures the child daily. Please check all the choices that best describe your child's behavior. If you are not sure, please choose the closest response based on your experience. **Children at your child's age are not necessarily expected to use all the behaviors listed.**

Emotion and Eye Gaze

1. Do you know when your child is happy and when your child is upset? ❒ Not Yet ❒ Sometimes ❒ Often
2. When your child plays with toys, does he/she look at you to see if you are watching? ❒ Not Yet ❒ Sometimes ❒ Often
3. Does your child smile or laugh while looking at you? ❒ Not Yet ❒ Sometimes ❒ Often
4. When you look at and point to a toy across the room, does your child look at it? ❒ Not Yet ❒ Sometimes ❒ Often

Communication

5. Does your child let you know that he/she needs help or wants an object out of reach? ❒ Not Yet ❒ Sometimes ❒ Often
6. When you are not paying attention to your child, does he/she try to get your attention? ❒ Not Yet ❒ Sometimes ❒ Often
7. Does your child do things just to get you to laugh? ❒ Not Yet ❒ Sometimes ❒ Often
8. Does your child try to get you to notice interesting objects—just to get you to look at the objects, not to get you to do anything with them? ❒ Not Yet ❒ Sometimes ❒ Often

Gestures

9. Does your child pick up objects and give them to you? ❒ Not Yet ❒ Sometimes ❒ Often
10. Does your child show objects to you without giving you the object? ❒ Not Yet ❒ Sometimes ❒ Often
11. Does your child wave to greet people? ❒ Not Yet ❒ Sometimes ❒ Often
12. Does your child point to objects? ❒ Not Yet ❒ Sometimes ❒ Often
13. Does your child nod his/her head to indicate *yes*? ❒ Not Yet ❒ Sometimes ❒ Often

Sounds

14. Does your child use sounds or words to get attention or help? ❒ Not Yet ❒ Sometimes ❒ Often
15. Does your child string sounds together, such as *uh oh, mama, gaga, bye bye, bada*? ❒ Not Yet ❒ Sometimes ❒ Often
16. About how many of the following consonant sounds does your child use: *ma, na, ba, da, ga, wa, la, ya, sa, sha*? ❒ None ❒ 1–2 ❒ 3–4 ❒ 5–8 ❒ over 8

Words

17. About how many different words does your child use meaningfully that you recognize (such as *baba* for bottle; *gaggie* for doggie)? ❒ None ❒ 1–3 ❒ 4–10 ❒ 11–30 ❒ over 30
18. Does your child put two words together (for example, *more cookie*, *bye bye Daddy*)? ❒ Not Yet ❒ Sometimes ❒ Often

Understanding

19. When you call your child's name, does he/she respond by looking or turning toward you? ❒ Not Yet ❒ Sometimes ❒ Often
20. About how many different words or phrases does your child understand without gestures? For example, if you say "where's your tummy," "where's Daddy," "give me the ball," or "come here," without showing or pointing, your child will respond appropriately. ❒ None ❒ 1–3 ❒ 4–10 ❒ 11–30 ❒ over 30

Object Use

21. Does your child show interest in playing with a variety of objects? ❒ Not Yet ❒ Sometimes ❒ Often
22. About how many of the following objects does your child use appropriately: cup, bottle, bowl, spoon, comb or brush, toothbrush, washcloth, ball, toy vehicle, toy telephone? ❒ None ❒ 1–2 ❒ 3–4 ❒ 5–8 ❒ over 8
23. About how many blocks (or rings) does your child stack? **Stacks** ❒ None ❒ 2 blocks ❒ 3–4 blocks ❒ 5 or more
24. Does your child pretend to play with toys (for example, feed a stuffed animal, put a doll to sleep, put an animal figure in a vehicle)? ❒ Not Yet ❒ Sometimes ❒ Often

Do you have any concerns about your child's development? ❒ yes ❒ no If yes, please describe on back.

CSBS DP Infant-Toddler Checklist: Screening Report

Child's name: _____ ***Date filled out:*** _____

Date of birth: _____

Chronological age[1]: _____

[1]If child is 4 or more weeks premature, use corrected age. Calculate chronological age by subtracting Date of birth from Date the Checklist was filled out.

Checklist Results

Predictor	Raw Score		Standard Score[a,b]	Percentile Rank[b]	Concern[c]
Emotion and Eye Gaze					
Communication					
Gestures					
SOCIAL COMPOSITE					
Sounds					
Words					
SPEECH COMPOSITE					
Understanding					
Object Use					
SYMBOLIC COMPOSITE					
TOTAL					

[a] The standard scores are based on a mean of 10 and SD of 3 for the Composite Scores and a mean of 100 and SD of 15 for the Total Score. (Refer to the *CSBS DP Manual*, *First Normed Edition*, for standard scores and tables of norms.)

[b] Criterion levels for concern are set at more than 1.25 SD below the mean as follows: Standard Scores at or below 6 for the Composite Scores and 81 for the Total Score; Percentiles at or below 10. (Refer to the *CSBS DP Manual*, *First Normed Edition,* for standard scores, percentiles, and tables of norms.)

[c] After filling in Standard Score and Percentile Rank, if below criterion level, write *Yes* in the Concern box. If at or above criterion level, leave blank. A child should be referred for an evaluation if the Social Composite, Symbolic Composite, *or* the Total Score is below criterion level. A child should be monitored carefully if the Speech Composite is below criterion level; administer a Checklist again in 3 months, and if the child's scores remain below criterion level, refer for a developmental evaluation.

Recommendation

Based on the information provided on the Infant-Toddler Checklist and the results shown above, the following recommendation is made at this time (check one):

- ❒ This child currently communicates as expected for his or her age. Because new skills are emerging each month, it is important to monitor this child's development by asking the child's caregiver to complete the Checklist again in 3 months.
- ❒ This child should be carefully monitored. Re-administer the Checklist in 3 months to determine if a developmental evaluation will become advisable.
- ❒ This child should be referred for a developmental evaluation.

Cut-off Scores for the CSBS DP Infant-Toddler Checklist

		COMPOSITES			TOTAL
		Social	**Speech**	**Symbolic**	
6 months	***No Concern***	8 to 26	2 to 14	3 to 17	13 to 57
	Concern	0 to 7	0 to 1	0 to 2	0 to 12
7 months	***No Concern***	8 to 26	2 to 14	3 to 17	14 to 57
	Concern	0 to 7	0 to 1	0 to 2	0 to 13
8 months	***No Concern***	8 to 26	4 to 14	4 to 17	16 to 57
	Concern	0 to 7	0 to 3	0 to 3	0 to 15
9 months	***No Concern***	9 to 26	4 to 14	4 to 17	18 to 57
	Concern	0 to 8	0 to 3	0 to 3	0 to 17
10 months	***No Concern***	12 to 26	5 to 14	5 to 17	23 to 57
	Concern	0 to 11	0 to 4	0 to 4	0 to 22
11 months	***No Concern***	13 to 26	5 to 14	6 to 17	25 to 57
	Concern	0 to 12	0 to 4	0 to 5	0 to 24
12 months	***No Concern***	14 to 26	6 to 14	7 to 17	28 to 57
	Concern	0 to 13	0 to 5	0 to 6	0 to 27
13 months	***No Concern***	15 to 26	6 to 14	8 to 17	29 to 57
	Concern	0 to 14	0 to 5	0 to 7	0 to 28
14 months	***No Concern***	16 to 26	7 to 14	9 to 17	33 to 57
	Concern	0 to 15	0 to 6	0 to 8	0 to 32
15 months	***No Concern***	18 to 26	7 to 14	10 to 17	35 to 57
	Concern	0 to 17	0 to 6	0 to 9	0 to 34
16 months	***No Concern***	18 to 26	7 to 14	11 to 17	36 to 57
	Concern	0 to 17	0 to 6	0 to 10	0 to 35
17 months	***No Concern***	18 to 26	7 to 14	11 to 17	37 to 57
	Concern	0 to 17	0 to 6	0 to 10	0 to 36
18 months	***No Concern***	18 to 26	8 to 14	11 to 17	38 to 57
	Concern	0 to 17	0 to 7	0 to 10	0 to 37
19 months	***No Concern***	18 to 26	8 to 14	11 to 17	38 to 57
	Concern	0 to 17	0 to 7	0 to 10	0 to 37
20 months	***No Concern***	19 to 26	8 to 14	12 to 17	39 to 57
	Concern	0 to 18	0 to 7	0 to 11	0 to 38
21 months	***No Concern***	19 to 26	9 to 14	12 to 17	40 to 57
	Concern	0 to 18	0 to 8	0 to 11	0 to 39
22 months	***No Concern***	19 to 26	9 to 14	12 to 17	40 to 57
	Concern	0 to 18	0 to 8	0 to 11	0 to 39
23 months	***No Concern***	19 to 26	9 to 14	13 to 17	42 to 57
	Concern	0 to 18	0 to 8	0 to 12	0 to 41
24 months	***No Concern***	19 to 26	10 to 14	13 to 17	42 to 57
	Concern	0 to 18	0 to 9	0 to 12	0 to 41
		Social	**Speech**	**Symbolic**	**TOTAL**

Instructions and Permissions for Use of the M-CHAT

The Modified Checklist for Autism in Toddlers (M-CHAT; Robins, Fein, & Barton, 1999) is available for free download for clinical, research, and educational purposes. There are two authorized websites: the M-CHAT and supplemental materials can be downloaded from **www.firstsigns.org** or from Dr. Robins' website, at **http://www2.gsu.edu/~wwwpsy/faculty/robins.htm**

Users should be aware that the M-CHAT continues to be studied, and may be revised in the future. Any revisions will be posted to the two websites noted above.

Furthermore, the M-CHAT is a copyrighted instrument, and use of the M-CHAT must follow these guidelines:

(1) Reprints/reproductions of the M-CHAT must include the copyright at the bottom (© 1999 Robins, Fein, & Barton). No modifications can be made to items or instructions without permission from the authors.

(2) The M-CHAT must be used in its entirety. There is no evidence that using a subset of items will be valid.

(3) Parties interested in reproducing the M-CHAT in print (e.g., a book or journal article) or electronically (e.g., as part of digital medical records or software packages) must contact Diana Robins to request permission (drobins@gsu.edu).

Instructions for Use

The M-CHAT is validated for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorders (ASD). The M-CHAT can be administered and scored as part of a well-child check-up, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT was to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk for ASD will be diagnosed with ASD. To address this, we have developed a structured follow-up interview for use in conjunction with the M-CHAT; it is available at the two websites listed above. Users should be aware that even with the follow-up questions, a significant number of the children who fail the M-CHAT will not be diagnosed with an ASD; however, these children are at risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who fails the screening.

The M-CHAT can be scored in less than two minutes. Scoring instructions can be downloaded from **http://www2.gsu.edu/~wwwpsy/faculty/robins.htm or www.firstsigns.org**. We also have developed a scoring template, which is available on these websites; when printed on an overhead transparency and laid over the completed M-CHAT, it facilitates scoring. Please note that minor differences in printers may cause your scoring template not to line up exactly with the printed M-CHAT.

Children who fail more than 3 items total or 2 critical items (particularly if these scores remain elevated after the follow-up interview) should be referred for diagnostic evaluation by a specialist trained to evaluate ASD in very young children. In addition, children for whom there are physician, parent, or other professional's concerns about ASD should be referred for evaluation, given that it is unlikely for any screening instrument to have 100% sensitivity.

M-CHAT

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.

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?	Yes No

SWYC™: 18 months

18 months, 0 days to 22 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Runs	0	1	2
Walks up stairs with help	0	1	2
Kicks a ball	0	1	2
Names at least 5 familiar objects - like ball or milk	0	1	2
Names at least 5 body parts - like nose, hand, or tummy	0	1	2
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Tufts Children's Hospital

********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	(Y)	(N)
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	(Y)	(N)
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	(Y)	(N)
4 Has a family member's drinking or drug use ever had a bad effect on your child?	(Y)	(N)

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	(0)	(1)	(2)	(3)
7 Feeling down, depressed, or hopeless?	(0)	(1)	(2)	(3)

	No tension	Some tension	A lot of tension	Not applicable
8 In general, how would you describe your relationship with your spouse/partner?	○	○	○	○

	No difficulty	Some difficulty	Great difficulty	Not applicable
9 Do you and your partner work out arguments with:	○	○	○	○

10 During the past week, how many days did you or other family members read to your child? (0) (1) (2) (3) (4) (5) (6) (7)

SWYC™: 24 months

23 months, 0 days to 28 months, 31 days
V1.08, 9/1/19

Child's Name:

Birth Date:

Today's Date:

DEVELOPMENTAL MILESTONES

Most children at this age will be able to do some (but not all) of the developmental tasks listed below. Please tell us how much your child is doing each of these things. PLEASE BE SURE TO ANSWER ALL THE QUESTIONS.

	Not Yet	Somewhat	Very Much
Names at least 5 body parts - like nose, hand, or tummy	0	1	2
Climbs up a ladder at a playground	0	1	2
Uses words like "me" or "mine"	0	1	2
Jumps off the ground with two feet	0	1	2
Puts 2 or more words together - like "more water" or "go outside"	0	1	2
Uses words to ask for help	0	1	2
Names at least one color	0	1	2
Tries to get you to watch by saying "Look at me"	0	1	2
Says his or her first name when asked	0	1	2
Draws lines	0	1	2

PRESCHOOL PEDIATRIC SYMPTOM CHECKLIST (PPSC)

These questions are about your child's behavior. Think about what you would expect of other children the same age, and tell us how much each statement applies to your child.

		Not at all	Somewhat	Very Much
Does your child...	Seem nervous or afraid?	0	1	2
	Seem sad or unhappy?	0	1	2
	Get upset if things are not done in a certain way?	0	1	2
	Have a hard time with change?	0	1	2
	Have trouble playing with other children?	0	1	2
	Break things on purpose?	0	1	2
	Fight with other children?	0	1	2
	Have trouble paying attention?	0	1	2
	Have a hard time calming down?	0	1	2
	Have trouble staying with one activity?	0	1	2
Is your child…	Aggressive?	0	1	2
	Fidgety or unable to sit still?	0	1	2
	Angry?	0	1	2
Is it hard to…	Take your child out in public?	0	1	2
	Comfort your child?	0	1	2
	Know what your child needs?	0	1	2
	Keep your child on a schedule or routine?	0	1	2
	Get your child to obey you?	0	1	2

Tufts Children's Hospital

********** Please continue on the back **********

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

	Many times a day	A few times a day	A few times a week	Less than once a week	Never
Does your child bring things to you to show them to you?	○	○	○	○	○

	Always	Usually	Sometimes	Rarely	Never
Is your child interested in playing with other children?	○	○	○	○	○
When you say a word or wave your hand, will your child try to copy you?	○	○	○	○	○
Does your child look at you when you call his or her name?	○	○	○	○	○
Does your child look if you point to something across the room?	○	○	○	○	○

How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐

What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi

PARENT'S CONCERNS

	Not At All	Somewhat	Very Much
Do you have any concerns about your child's learning or development?	○	○	○
Do you have any concerns about your child's behavior?	○	○	○

FAMILY QUESTIONS

Because family members can have a big impact on your child's development, please answer a few questions about your family below:

	Yes	No
1 Does anyone who lives with your child smoke tobacco?	Y	N
2 In the last year, have you ever drunk alcohol or used drugs more than you meant to?	Y	N
3 Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Y	N
4 Has a family member's drinking or drug use ever had a bad effect on your child?	Y	N

	Never true	Sometimes true	Often true
5 Within the past 12 months, we worried whether our food would run out before we got money to buy more.	○	○	○

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
6 Having little interest or pleasure in doing things?	0	1	2	3
7 Feeling down, depressed, or hopeless?	0	1	2	3

8 In general, how would you describe your relationship with your spouse/partner?	No tension ○	Some tension ○	A lot of tension ○	Not applicable ○
9 Do you and your partner work out arguments with:	No difficulty ○	Some difficulty ○	Great difficulty ○	Not applicable ○

10 During the past week, how many days did you or other family members read to your child?	0	1	2	3	4	5	6	7

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

10. How often does anyone, including family, scream or curse at you?[1]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Fairly often
    - ☐ Frequently

ASSISTANCE

11. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

Supported in part by a grant from the AAFP Foundation

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Has your child ever lived with a parent/caregiver who went to jail/prison?	☐
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	☐
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	☐
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	☐
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	☐
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	☐
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

CENTER for YOUTH WELLNESS
UCSF Benioff Children's Hospital Oakland

This tool was created in partnership with UCSF School of Medicine.

PART 2:	Please check "Yes" where apply. √

1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? ☐
   (for example, targeted bullying, assault or other violent actions, war or terrorism)
2. Has your child experienced discrimination? ☐
   (for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)
3. Has your child ever had problems with housing? ☐
   (for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more? ☐
5. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability? ☐
6. Has your child ever been separated from their parent or caregiver due to foster care, or immigration? ☐
7. Has your child ever lived with a parent or caregiver who died? ☐

How many "Yes" did you answer in Part 2?: ☐

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.	☐ # of days
4.	Use a **vaping device* containing nicotine and/or flavors**, or use any **tobacco products**†? Put "0" if none. **Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 5 BELOW, THEN STOP.**
- **If you put "1" or more for <u>Questions 1, 2, or 3</u> above, ANSWER QUESTIONS 5-10 BELOW.**
- **If you put "1" or more for <u>Question 4</u> above, ANSWER ALL QUESTIONS ON BACK PAGE.**

		Circle one	
5.	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
6.	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	**No**	**Yes**
7.	Do you ever use alcohol or drugs while you are by yourself, or ALONE?	**No**	**Yes**
8.	Do you ever FORGET things you did while using alcohol or drugs?	**No**	**Yes**
9.	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
10.	Have you ever gotten into TROUBLE while you were using alcohol or drugs?	**No**	**Yes**

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent.

The following questions ask about your use of any **vaping devices containing nicotine and/or flavors**, or use of any **tobacco products***. Circle your answer for each question.

	Circle one	
1. Have you ever tried to quit using, but couldn't?	**Yes**	**No**
2. Do you vape or use tobacco now because it is really hard to quit?	**Yes**	**No**
3. Have you ever felt like you were addicted to vaping or tobacco?	**Yes**	**No**
4. Do you ever have strong cravings to vape or use tobacco?	**Yes**	**No**
5. Have you ever felt like you really needed to vape or use tobacco?	**Yes**	**No**
6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school?	**Yes**	**No**
7. When you haven't vaped or used tobacco in a while (or when you tried to stop using)…		
a. did you find it hard to concentrate because you couldn't vape or use tobacco?	**Yes**	**No**
b. did you feel more irritable because you couldn't vape or use tobacco?	**Yes**	**No**
c. did you feel a strong need or urge to vape or use tobacco?	**Yes**	**No**
d. did you feel nervous, restless, or anxious because you couldn't vape or use tobacco?	**Yes**	**No**

**References:*

Wheeler, K. C., Fletcher, K. E., Wellman, R. J., & DiFranza, J. R. (2004). Screening adolescents for nicotine dependence: the Hooked On Nicotine Checklist. *J Adolesc Health*, *35*(3), 225–230;

McKelvey, K., Baiocchi, M., & Halpern-Felsher, B. (2018). Adolescents' and Young Adults' Use and Perceptions of Pod-Based Electronic Cigarettes. *JAMA Network Open*, *1*(6), e183535.

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	**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

For office coding: _____*0*_____*+*_____*+*_____*+*_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Suicide Behaviors Questionnaire-Revised (SBQ-R)

Name: _____

Date of Visit: _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. ***Have you ever thought about or attempted to kill yourself?***

☐ (1) Never

☐ (2) It was just a brief passing thought

☐ (3a) I have had a plan at least once to kill myself but did not try to do it

☐ (3b) I have had a plan at least once to kill myself and really wanted to die

☐ (4a) I have attempted to kill myself, but did not want to die

☐ (4b) I have attempted to kill myself, and really hoped to die

2. ***How often have you thought about killing yourself in the past year?***

☐ (0) Never

☐ (1) Rarely (1 time)

☐ (2) Sometimes (2 times)

☐ (3) Often (3-4 times)

☐ (4) Very Often (5 or more times)

3. ***Have you ever told someone that you were going to commit suicide, or that you might do it?***

☐ (1) No

☐ (2a) Yes, at one time, but did not really want to die

☐ (2b) Yes, at one time, and really wanted to do it

☐ (3a) Yes, more than once, but did not want to do it

☐ (3b) Yes, more than once, and really wanted to do it

4. ***How likely is it that you will attempt suicide someday?***

☐ (0) Never

☐ (1) No chance at all

☐ (2) Rather Unlikely

☐ (3) Unlikely

☐ (4) Likely

☐ (5) Rather Likely

☐ (6) Very Likely

Scoring

It consists of four Likert scale questions, with responses ranging from 0 (never) to 4 (very often). The total score for the SBQ-R falls within the range of 3 to 18.

To calculate the score, sum up the responses to the four questions. A total score of 11 or higher suggests a high risk of suicide.

A score between 7 and 10 indicates moderate risk, while a score of 6 or lower suggests low risk. This scoring system provides valuable information for identifying individuals at different levels of suicide risk and guiding appropriate interventions.

Score	Risk Level
11 or higher	High risk
7 to 10	Moderate risk
6 or lower	Low risk

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bolded and underlined	**Yes**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*." ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them*." ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** ☐Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

II. Response Protocol to C-SSRS Screening

(Linked to last item answered YES)

Item 1 – Mental Health Referral at discharge
Item 2 – Mental Health Referral at discharge
Item 3 – Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 6 – If over a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor
If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition: ☐ Mental Health Referral at discharge
☐ Care Team Consult (Psychiatric Nurse) and Patient Safety Monitor/ Procedures
☐ Psychiatric Consultation and Patient Safety Monitor/ Procedures

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Patient Sticker

Date: _____

Time: _____

RN Initials: _____

THE PATIENT SAFETY SCREENER (PSS-3)

This tool can be used to detect suicide risk in EDs and inpatient medical settings with patients ages 12 years and older.

Ask the following three questions exactly as worded. If the answer to Question 3 is Yes, ask Question 3a

Opening script: *Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy and it helps us to make sure we are not missing anything important*

1. In the past two weeks, have you felt down, depressed, or hopeless?

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

2. In the past two weeks, have you had thoughts of killing yourself?*

☐ **Yes** ☐ No ☐ Patient unable to complete ☐ Patient refused

3 In your lifetime, have you ever attempted to kill yourself?*

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

3a. If yes, when did this happen?

☐ Within past 24 hours (including today) ☐ Within last month (but not today) ☐ Between 1 and 6 months ago

☐ More than 6 months ago ☐ Patient unable to complete ☐ Patient refused

**Patient presenting with a current suicide attempt is an automatic Yes on Items 2 and 3.*

Notes:_____

_____

_____

INTERPRETATION

"Yes" to Item 2 (ideation)? = ☐ *Positive screen*

''Within past 24 hours", "Within last month" or "Between 1 and 6 months ago" on Item 3a = ☐ *Positive screen*

RESPONDING TO A POSITIVE SCREEN

Administer a secondary screener tool (like the ESS-6) to stratify risk and guide your risk mitigation plan

California Pediatric Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **children** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
  If initial negative screening test occurred prior to 6 months of age, repeat testing should occur at age 6 months or older
- Do not treat for LTBI until active TB disease has been excluded:
  For children with TB symptoms or abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥2 mg/kg/day, or ≥15 mg/day for ≥2 weeks) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: _____

Assessment Date: _____

Patient Name: _____

Date of Birth: _____

See the California Pediatric TB Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)

California TB Pediatric Risk Assessment User Guide

Avoid testing persons at low risk

Routine testing of persons without risk factors is not recommended and may result in unnecessary evaluations and treatment because of falsely positive test results.

Local recommendations, mandated testing and other risk factors

Several risk factors for TB that have been used to select children for TB screening historically or in mandated programs are not included among the 3 components of this risk assessment. This is purposeful in order to focus testing on children at highest risk. However, certain populations may be mandated for testing by statute, regulation, or policy. This risk assessment does not supersede any mandated testing. Testing can also be considered in children with frequent exposure to adults at high risk of TB infection, such as those with extensive foreign travel in areas with high TB rates. Local recommendations should also be considered in testing decisions. Local TB control programs and clinics can customize this risk assessment according to local recommendations. **Providers should check with local TB control programs for local recommendations.** A directory of TB Control Programs is available on the CTCA website. (https://www.ctca.org/locations.html)

Most patients with LTBI should be treated

Persons with risk factors who test positive for LTBI should generally be treated once active TB disease has been ruled out with a physical exam, chest radiograph and, if indicated, sputum smears, cultures, and nucleic acid amplification testing (NAAT). However, clinicians should not feel compelled to treat persons who have no risk factors but have a positive test for LTBI.

When to repeat a risk assessment and testing

Risk assessments should be completed for new patients, patients thought to have new potential exposures to TB since last assessment, and during routine pediatric well-child visits. Repeat risk assessments should be based on the activities and risk factors specific to the child. Children who volunteer or work in health care settings might require annual testing and should be considered separately. Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment (unless they were <6 months of age at the time of testing). In general, new risk factors would include new close contact with an infectious TB case or new immunosuppression, but could also include foreign travel.

Immunosuppression

The exact level of immunosuppression that predisposes to increased risk for TB progression is unknown. The threshold of steroid dose and duration used in the Pediatric TB Risk Assessment are based on data in adults and in accordance with ACIP recommendations for live vaccines in children receiving immunosuppression.

Foreign travel or residence

Travel or residence in countries with an elevated TB rate may be a risk for TB exposure in certain circumstances (e.g., extended duration, likely contact with persons with infectious TB, high prevalence of TB in travel location, non-tourist travel). The duration of at least 1 consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure. TB screening tests can be falsely negative within the 8 weeks after exposure, so are best obtained 8 weeks after a child's return.

IGRA preference in non-U.S.-born children ≥2 years old

Because IGRA has increased specificity for TB infection in children vaccinated with BCG, IGRA is preferred over the tuberculin skin test for non-U.S.-born children ≥2 years of age. IGRAs can be used in children <2 years of age, however, there is an overall lack of data in this age group, which complicates interpretation of test results. In BCG vaccinated immunocompetent children with a positive TST, it may be appropriate to confirm a positive TST with an IGRA. If IGRA is not done the TST result should be considered the definitive result.

Negative test for LTBI does not rule out active TB

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. A negative TST or IGRA in a patient with active TB disease can be a sign of extensive disease. Any suspicion for active TB disease or extensive exposure to TB should prompt an evaluation for active TB disease, including physical exam, symptom review, and 2-view chest x-ray.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating latent TB infection have been shown to be as effective as 9 months of isoniazid, and are more likely to be completed. Use of these shorter regimens is preferred in most patients, although the 12 week regimen is not recommended for children <2 years of age or children on antiretroviral medications. It is under study in pregnancy. Drug- drug interactions and contact to drug resistant TB are other contra-indications for shorter regimens.

Shorter duration LTBI treatment regimens

Medication	Frequency	Duration
Rifampin	Daily	4 months
Isoniazid + rifapentine	Weekly	12 weeks*

* 11-12 doses in 16 weeks required for completion.

Refusal of recommended LTBI treatment

Refusal should be documented. Recommendations for treatment should be made at future encounters with medical services. If treatment is later accepted, TB disease should be excluded and chest x-ray repeated if it has been more than 6 months from the initial evaluation for children 5 years or older and 3 months for children less than 5 years of age.

Symptoms that should trigger evaluation for active TB

Patients with any of the following symptoms that are otherwise unexplained should be evaluated for active TB disease: cough for more than 2-3 weeks, fevers, night sweats, weight loss, lymphadenopathy, hemoptysis or excessive fatigue.

Resources

Fact Sheets for LTBI Regimens, Isoniazid+Rifapentine, Rifampin, and Isoniazid are available on the TBCB LTBI Treatment page. (www.cdph.ca.gov/LTBITreatment)

American Academy of Pediatrics, Red Book Online, Tuberculosis is available on the Red Book Online website. (https://redbook.solutions.aap.org/chapter.aspx?sectionid=189640207&bookid=2205)

Abbreviations

AFB= acid-fast bacilli BCG= Bacillus Calmette-Guérin
CXR= chest x-ray DOT= directly observed therapy
IGRA=interferon gamma release assay LTBI= latent TB infection
MDR =multiple drug resistant NAAT= nucleic acid amplification testing
SAT= self-administered therapy TST= tuberculin skin test

Hepatitis Risk Assessment Tool

"Hepatitis" means inflammation of the liver and is usually caused by a virus. In the U.S., the most common types are Hepatitis A, Hepatitis B, and Hepatitis C. Millions of Americans are living with viral hepatitis but most do not know they are infected. People can live with chronic hepatitis for decades without having symptoms.

This assessment will help determine if you should be vaccinated and/or tested for viral hepatitis by asking a series of questions. Depending on your answers, you will be given a tailored recommendation that you should discuss with your doctor or your professional healthcare provider. Any information received through the use of this tool is not medical advice and should not be treated as such.

Questions	Recommendations & Explanation
1. Have you ever been diagnosed with a clotting factor disorder?	If yes, talk to your doctor about getting vaccinated for Hepatitis A.
2. Have you ever been diagnosed with a chronic liver disease?	If yes, talk to your doctor about getting vaccinated for Hepatitis A and B.
3. Were you or at least one parent born outside of the United States?	If yes, talk to a doctor about getting a blood test for Hepatitis B. Many parts of the world have high rates of hepatitis B, including the Amazon Basin, parts of Asia, Sub-Saharan Africa and the Pacific Islands.
4. Do you currently live with someone who is diagnosed with Hepatitis B?	If yes, talk to a doctor about getting a blood test for Hepatitis B.
5. Have you previously lived with someone who has been diagnosed with hepatitis B?	If yes, talk to a doctor about getting a blood test for hepatitis B.
6. Have you recently been diagnosed with a sexually transmitted disease (STD)?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
7. Have you been diagnosed with diabetes?	If yes, talk to a doctor about getting vaccinated for Hepatitis B.
8. Have you been diagnosed with HIV/AIDS?	If yes, talk to a doctor about getting vaccinated for Hepatitis B and getting a blood test for Hepatitis B and Hepatitis C.
9. If you are a man, do you have sexual encounters with other men?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B.
10. Do you currently inject drugs?	If yes, talk to a doctor about getting vaccinated for Hepatitis A and B, and getting a blood test for Hepatitis B and C.
11. Were you born from 1945-1965?	If yes, talk to a doctor about getting a blood test for Hepatitis C
12. Have you ever received a blood transfusion or organ transplant before July 1992?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
13. Have you ever received a clotting factor concentrate before 1987?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
14. Have you ever injected drugs, even if just once?	If yes, talk to a doctor about getting a blood test for Hepatitis C.
15. Do you plan on traveling outside of the United States within the next year?	If yes, talk to a doctor about what vaccines may be needed for travel outside the U.S.

INLAND EMPIRE HEALTH PLAN

Sudden Cardiac Arrest (SCA) & Sudden Cardiac Death (SCD) Screening

- SCA and SCD screening should be performed for all children (athlete or not) at the same time as the Pediatric Physical Examination or at a minimum of every 3 years or on entry into middle or junior high school and into high school.
- AAP recommended 4 questions directed toward SCA and SCD detection for which a positive response suggested an increased risk for SCA and SCD

A positive response from the 4 questions below or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist.		
1. Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises, such as doorbells, alarm clocks, and ringing telephones?	◯ Yes	◯ No
2. Have you ever had exercise-related chest pain or shortness of breath?	◯ Yes	◯ No
3. Has anyone in your immediate family (parents, grandparents, siblings) or other, more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or SIDS.	◯ Yes	◯ No
4. Are you related to anyone with HCM or hypertrophic obstructive cardiomyopathy, Marfan syndrome, ACM, LQTS, short QT syndrome, BrS, or CPVT or anyone younger than 50 years with a pacemaker or implantable defibrillator?	◯ Yes	◯ No

◯ **HIGH** Risk needs prompt further investigation	◯ **LOW** Risk

Provider Name: _____ Provider Signature:_____ Assessment Date: _____	Patient Name: _____ Date of Birth: _____

References:
https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-all-children-should-be-screened-for-potential-heart-related-issues/
https://publications.aap.org/pediatrics/article/148/1/e2021052044/179969/Sudden-Death-in-the-Young-Information-for-the
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-017-MRR-Standards.pdf

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