THSteps Forms

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Appendix C

C.1 Claim Forms
Providers must order CMS-1500 and ADA Dental Claims Forms from the vendor of their choice. Copies cannot be used. Claims filing instructions and examples of the claim forms are located in “Claims Filing” on page 5-1.

Refer to: “CMS-1500 Claim Filing Instructions” on page 5-26.
“CMS-1500 Blank Claim Form” on page 5-28.
“2006 American Dental Association (ADA) Dental Claim Filing Instructions” on page 5-43.

C.2 Child Health Clinical Records
The use of forms ECH 1–7 is optional. These forms were developed to assist providers in documenting all components of the medical checkup and can be downloaded from the THSteps website at secure.thstepsproducts.com/forms/ths_forms.htm. Lead poisoning screening questionnaires can be downloaded from the Childhood Lead Poisoning Prevention Program website at www.dshs.state.tx.us/lead/providers.shtml.

Tuberculosis screening questionnaires can be downloaded from the Tuberculosis Elimination Division website at www.dshs.state.tx.us/idcu/disease/tb/forms/default.asp?clinic. These forms are also available within this appendix.

Forms CH-9W through CH-12W are only available by calling THSteps at 1-512-458-7745.

<table>
<thead>
<tr>
<th>Stock Number</th>
<th>Form</th>
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<tbody>
<tr>
<td>CH-9W</td>
<td>Growth Chart - Infant Girl</td>
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<tr>
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</tr>
<tr>
<td>CH-11W</td>
<td>Growth Chart - Child Girl</td>
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</tr>
<tr>
<td></td>
<td>Form Pb-110, Risk Assessment for Lead Exposure</td>
</tr>
<tr>
<td></td>
<td>TB Questionnaire</td>
</tr>
</tbody>
</table>

For forms for documenting medical checkups for adolescents of all ages, please refer to sources such as Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd edition, revised), located at www.brightfutures.org or the Guidelines for Adolescent Preventive Services (GAP) Implementation Materials located at: www.ama-assn.org/ama/pub/category/1981.html. For nutritional screening for all ages, refer to Bright Futures.

C.3 Guidelines for Tuberculosis Skin Testing
For information on procedures for tuberculosis skin testing, refer to the Department of State Health Services (DSHS) tuberculosis web page at www.dshs.state.tx.us/idcu/disease/tb/.

C.4 Laboratory Forms
For information on procedures for submission of laboratory forms, refer to the DSHS Laboratory Services Section’s web page at www.dshs.state.tx.us/lab/MRS_forms.shtml.
C.5 Child Health History (2 Pages)

**Child Health History**

Department of State Health Services

Child Health Record

Preventive Health Visit

**Pregnancy and Birth**

G ____ P ____ AB ____

Total number of living children ______ Weight gain/loss ______

Mother’s age at birth ______

Number of years between previous pregnancy and this child ______

Trimester Prenatal Care Began: 1 2 3

Prenatal Care Provider ____________________________

Vitamins: ___ Y ___ N Iron: ___ Y ___ N

If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: ___ Y ___ N*

*If yes, proceed with “Child’s Medical History.”

**Maternal Complications**

- Vaginal bleeding
- Anemia
- Hypertension
- Rh negative
- Diabetes
- Premature labor
- Injury/hospitalization/surgery

**Maternal Substance Use**

- OTC meds
- Prescription meds
- Tobacco
- Alcohol
- Street drugs
- Caffeine

**Family Medical History**

Abbreviations for relatives listed below.

M - Mother
F - Father
S - Sibling
MA - Maternal Aunt
MU - Maternal Uncle
PGM - Paternal Grandmother
PGF - Paternal Grandfather
PA - Paternal Aunt
PU - Paternal Uncle

- Anemia/blood disorder
- Heart disease before age 50
- Cholesterol req. treatment
- Hypertension/stroke
- Asthma/allergy
- Cancer
- Diabetes
- Epilepsy/seizures
- Kidney problems
- Muscle/bone disease
- Genetic disease or major birth defects
- Childhood hearing impairment
- Tuberculosis

- HIV + individual in household (do not identify)

- Other immunosuppression
- Dental decay
- Alcohol/drug abuse
- Tobacco use
- Learning disorder
- Mental retardation
- Psychiatric disorder
- Physical/sexual/emotional abuse
- Domestic violence

- Other

**Examination/Other:**

- Transfusion
- Jaundice req. treatment
- Infection
- Seizures
- Transfusion
- Jaundice req. treatment
- Seizures

**Newborn blood screening (date/location):**

1. ________________________________________________________
2. ________________________________________________________

**Newborn hearing test (in hospital):**

- Normal
- Abnormal

Type of test: ____ ABR ____ OAE ____ Unknown

Referral made: ___ Y ___ N

Comments:

**Child’s Medical History**

Immunizations current: ___ Y ___ N ___ Record unavailable

Dental care/sealants current: ___ Y ___ N

- Trauma/injuries
- Hospitalizations
- Surgery
- Medications
- Anemia
- Early childhood caries
- Hepatitis
- Strep throat
- Ear infections
- Bladder/kidney infections
- Pneumonia
- Developmental delays

Examination:

- Vision problems
- Hearing problems
- Seizures
- Environmental toxin exposure (lead, etc.)
- Allergies
- Asthma
- Eczema
- Substance use (alcohol, drug, tobacco)
- Other

Date: ________________ Signature/Title: ____________________

Signature/Title: ____________________

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Child Health History

If used for documentation: ____________________________________________

Patient’s Name: _________________________________________________

Date: ___________________________________________________________________________

Progress Notes

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C.6 Child Health Record (Birth–1 Month) (2 Pages)

**Birth–1 Month**

Department of State Health Services
Child Health Record
Preventive Health Visit

**Family Profile and Health**

No change in household since last visit
Child lives with:
- Mother
- Father
- Stepparent
- Grandparent
- Other

Total adults living in home:
Total children living in home:
Primary caretaker for this child:

Family’s concerns/problems:

**Client Information**

Name: _______________________
DOB: _______ / _______ / ______ Age: __________ Sex: __________
SSN/Record No.: ______________________
Race/Ethnicity: ______________________
Informant/Relationship: ______________________
Medical Home: ______________________

**Nutrition**

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems*
- Y
- N
*If answered yes, further assessment needed.

Breast-fed: Number of feedings in last 24 hours:

Length of feedings: ______________________

WIC: ______________________

Formula-fed:
- Type:
- Iron fortified:

Ounces consumed in 24 hours: __________

Fluoride: ______________________

Solid foods introduced at age:

**Development**

Parent’s concerns:

Developmental Screening: ______________________
- P
- F

Type of Developmental Screen:
Standardized Parent Questionnaire: ______________________
Standardized Observational Screen: ______________________

Other: ______________________

Further assessment needed: ______________________

Mental Health (see “Key Elements” on reverse side):

**Child’s Health**

Allergies:

Does the system review note any problems or parent concerns:
- Y
- N

Explain:

Major illness, injury, hospitalization, surgery (state when and describe):

Medications taken regularly — Type/Reason:

**Physical Examination**

Temp: __________
Pulse: __________
Resp: __________
FOC: __________
Height: __________
Weight: __________

(%) ______________________
(%) ______________________
(%) ______________________

**Assessment**

Plan

WIC: ______________________

Immunizations:
- Up to date
- To be given today
- Deferred

Explain:

Lab:

Newborn Screening: ______________________

Next appointment:

**Nutritional**

Whereas developmental, special diet, inappropriate weight gain/loss, chronic GI problems* ______________________

*If answered yes, further assessment needed.

Breast-fed: Number of feedings in last 24 hours:

Length of feedings: __________

WIC: ______________________

Formula-fed:
- Type:
- Iron fortified:

Ounces consumed in 24 hours: __________

Fluoride: ______________________

Solid foods introduced at age:

**Sensory**

Vision Screen: ______________________

Hearing Screen: ______________________

Screen used:

**Health Education**

Injury Prevention:
- Car safety restraints
- Crib safety
- Burns
- Falls
- Drowning/bath safety
- 911
- Sleep position (SIDS)
- Passive smoking

Behavior:
- Crying/colic
- Sleeping
- Infant temperature

Health Promotion:
- Care of skin, umbilical cord, circumcision
- Family planning
- Well-child care
- When to call doctor

Nutrition:
- Breastfeeding
- No solids until 4 months
- Formula preparation
- Infant held for bottle
- No bottle in bed

**Additional documentation:**

Date: ______________________

Signature/Title: ______________________

Signature/Title: ______________________
Birth–1 Month
If used for documentation:____________________________________
Patient’s Name: ____________________________________________
Date: _____________________________________________________

Key Elements

**Systems Review**

- **Skin:** Rashes, infections, jaundice, cyanosis
- **Eyes:** Eye discharge, excessive tearing
- **Ears:** Hearing or ear problems
- **Nose/Mouth/Throat:** Nasal congestion
- **Cardio/respiratory:** History of murmur, trouble with breathing, wheezing
- **Gastrointestinal:** Bowel movement frequency, problems/concerns, vomiting
- **Genitourinary:** (Male) Normal stream, circumcision, number of wet diapers
- **Neuromuscular:** Seizures, sucking reflex, swallowing
- **Musculoskeletal:** Range of motion

**Mental Health**

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

- **Feelings:** Anxious, cries excessively or too little, irritable
- **Behavior:** Overactivity, listlessness
- **Social Interaction:** Failure to respond socially
- **Thinking:** Unattentive
- **Physical Problems:** Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
- **Other:** Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

**Progress Notes**

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C.7  Child Health Record (2–6 Months) (2 Pages)

2–6 Months

Department of State Health Services
Child Health Record
Preventive Health Visit

Client Information

Name: ________________________
DOB: _______/_____/_______ Age: ______ Sex: ______
SSN/Record No.: ____________________________
Race/Ethnicity: ____________________________
Informant/Relationship: ______________________
Medical Home: _____________________________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems*  _____ Y _____ N
*If answered yes, further assessment needed.

Breast-fed: Number of feedings in last 24 hours: ____________
Length of feedings: ____________
WIC:  _____ Y _____ N
Formula-fed: Type: ____________________________
Iron fortified:  _____ Y _____ N
Ounces consumed in 24 hours: ____________ Fluoride:  _____ Y _____ N
Solid foods introduced at age: ____________

Sensory

Vision Screen:  _____Normal _____ Abnormal
Hearing Screen:  _____Normal _____ Abnormal
Screen used:  ________Hearing Checklist for Parents

Health Education

Injury Prevention
  ___Car safety restraints
  ___Falls, Infant walker
  ___Burns
  ___Choking management
  ___Sleep position (SIDS)
  ___Passive smoking
  ___Pool/bath safety
Behavior
  ___Parent/infant interaction
  ___Sleeping
  ___Inappropriate expectations
  ___Daycare/babysitters

Nutrition

Breastfeeding
  ___Immunizations
  ___Thermometer use, Tylenol
  ___Teething, wipe teeth
  ___When to call doctor
  ___Well-child care
  ___Family planning

Health Promotion

Newborn Screening: Up to date  _____ T o be done today

Assessment

Health Education

Plan

WIC:  _____Referred ___ Refused _  ___ N/A
Immunizations:  Up to date  To be given today  ____ Deferred
Explain:
Lab:
Newborn Screening:  Up to date _____ To be done today
Next appointment:

Date: ________________________ Signature/Title: ________________________
Date: ________________________ Signature/Title: ________________________

Family Profile and Health

No change in household since last visit

Child lives with:
  ____ Mother  ____ Father  ____ Stepparent  ____ Grandparent
  ____ Other

Total adults living in home: ________________________
Total children living in home: ________________________
Primary caretaker for this child: ________________________
Relationship: ____________________________

Family’s concerns/problems:

Development

Parent’s concerns:

Developmental Screening:  _____ P _____ F
Type of Developmental Screen:
  Standardized Parent Questionnaire: ____________________________
  Standardized Observational Screen: ____________________________
  Other: ____________________________
Further assessment needed:  _____ Y _____ N

Mental Health

(see “Key Elements” on reverse side):

Child’s Health

Allergies:
Does the system review note any problems or parent concerns:  _____ Y _____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit): ____________________________

Medications taken regularly — Type/Reason:

Physical Examination

Hct/Hgb: ____________ Lead: ____________
Temp: ____________ Pulse: ____________ Resp: ____________
FOC: ____________ Height: ____________ Weight: ____________
(%) ____________ (%) ____________ (%) ____________

N A NE

Appearance
Heart/pulses
Skin/nodes
Abdomen
Eyes (RR)
Genitalia/anus
Ears
Spine/hips
Nose
Extremities
Mouth/throat
Neurologic:
Teeth
Muscle tone
Neck
DTRs
Chest/breasts
Primitive reflexes

Additional documentation:
2–6 Months
If used for documentation: ____________________________________
Patient’s Name: ____________________________________________
Date: _____________________________________________________

Key Elements

Systems Review
Skin: Rashes, infections
Ears: Hearing or ear problems
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting
Genitourinary: (Male) Normal stream, number of wet diapers
Neuromuscular: Seizures, coordinated movements
Musculoskeletal: Fractures, range of motion

Mental Health
The mental health assessment of this age also includes the developmental assessment and information from the family profile.
Feelings: Anxious, cries excessively or too little, irritable
Behavior: Overactivity, listlessness
Social Interaction: Failure to respond socially
Thinking: Unattentive
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

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# Child Health Record (7-12 Months) (2 Pages)

## 7–12 Months

Department of State Health Services  
Child Health Record  
Preventive Health Visit

### Client Information

Name: ___________________________  
DOB: _______ / _______ / _______  
Age: _______  
Sex: ___________________________

SSN/Record No.: ___________________________

Race/Ethnicity: ___________________________

Informant/Relationship: ___________________________

Medical Home: ___________________________

### Family Profile and Health

- No change in household since last visit

**Child lives with:**
- Mother  
- Father  
- Stepparent  
- Grandparent  
- Other

Total adults living in home: ___________________________

Total children living in home: ___________________________

Primary caretaker for this child: ___________________________

Relationship: ___________________________

Family’s concerns/problems:

### Development

**Parent’s concerns:**

Developmental Screening: _____P _____F

**Type of Developmental Screen:**

- Standardized Parent Questionnaire: ___________________________
- Standardized Observational Screen: ___________________________
- Other: ___________________________

Further assessment needed: _____Y _____ N

**Mental Health** (see “Key Elements” on reverse side):

### Child’s Health

**Allergies:**

Does the system review note any problems or parent concerns: _____Y _____ N

Explain:

Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly — Type/Reason:

### Physical Examination

**Temp**: _______  
**Pulse**: _______  
**Resp**: _______

**FOC**: _______  
**Height**: _______  
**Weight**: _______

 (%): _______  
(%) _______

### Neurologic

- Appearance: N A NE
- Head/fontanels: N A NE
- Skin/nodes: N A NE
- Eyes: N A NE
- Ears: N A NE
- Nose: N A NE
- Mouth/throat: N A NE
- Teeth: N A NE
- Neck: N A NE
- Chest/breasts: N A NE

**Heart/pulses:**

- Lungs: N A NE
- Abdomen: N A NE
- Genitalia/anus: N A NE
- Spine/hips: N A NE
- Extremities: N A NE

**Muscle tone:**

- DTRs: N A NE

### Additional documentation:

**Injury Prevention**

- Car safety restraints: N/A
- Falls (stairs, gates): N/A
- Choking management: N/A
- Water safety/temp: N/A
- Poisoning: N/A
- Child proofing: N/A
- Passive smoking: N/A

**Behavior**

- Parent/infant interaction, expectations: N/A
- Speech development: N/A
- Sleep: N/A
- Separation protest: N/A
- Daycare: N/A

**Health Education**

- Immunizations: N/A
- Teething: N/A
- Cleaning teeth: N/A
- When to call doctor: N/A
- Well-child care: N/A
- Dental appointment: N/A
- Family planning: N/A

**Nutrition**

- Breastfeeding support: N/A
- Introduction of solids: N/A
- No bottle in bed: N/A
- Off bottle by 1 year: N/A

**Health Promotion**

- Newborn Screening: N/A

- Lab:

- Newborn Screening: Up to date
- To be done today
- Hct/Hgb Lead
- Hep C (if 12 months old or older and born to HCV infected woman):

**Next appointment:**

---

Date: ___________________________  
Signature/Title: ___________________________

Signature/Title: ___________________________  

---

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7–12 Months
If used for documentation: ____________________________________________
Patient's Name: ____________________________________________________
Date: _____________________________________________________________

Key Elements

**Systems Review**

- **Skin:** Rashes, infections
- **Ears:** Hearing or ear problems
- **Cardio/respiratory:** History of murmur, trouble with breathing, wheezing
- **Gastrointestinal:** Bowel movement frequency, problems/concerns, vomiting
- **Genitourinary:** (Male) Normal stream
- **Neuromuscular:** Coordination
- **Musculoskeletal:** Fractures

**Mental Health**

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

- **Feelings:** Anxious, cries excessively or too little, irritable
- **Behavior:** Overactivity, listlessness
- **Social Interaction:** Failure to respond socially
- **Thinking:** Unattentive
- **Physical Problems:** Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
- **Other:** Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

**Progress Notes**

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13 Months–2 Years

Department of State Health Services
Child Health Record
Preventive Health Visit

Family Profile and Health

No change in household since last visit
Child lives with:
Mother   Father   Stepparent   Grandparent
Other
Total adults living in home:
Total children living in home:
Primary caretaker for this child:
Relationship:
Family's concerns/problems:

Development

Parent's concerns:
Developmental Screening: P F
Type of Developmental Screen:
Standardized Parent Questionnaire:
Standardized Observational Screen:
Other:
Further assessment needed:
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns:
Y N
Explain:
Medications taken regularly — Type/Reason:
Dental Care:

Physical Examination

Temp   Pulse   Resp
FOC   Height   Weight
(%)   (%)   (%)

N A NE N A NE

Appearance   Heart/pulses
Head/fontanels   Lungs
Skin/nodes   Abdomen
Eyes   Genitalia/anus
Ears   Spine/hips
Nose   Extremities
Mouth/throat   Neurologic:
Teeth   Muscle tone
Neck   DTRs

Chest/breasts

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental
Y N
*If answered yes, further assessment needed.
Usual Servings Per Day:
Dairy   Formula   Breast   Vegetables
WIC: Y N
Breads, cereal, rice, and pasta
Meat, poultry, fish, eggs, and dry beans
Fruits

Sensory

Vision Screen: Normal Abnormal
Hearing Screen: Normal Abnormal
Screen used:

Health Education

Injury Prevention
__ Car safety restraints
__ Choking, unsafe toys
__ Poisoning
__ Burns
__ Water safety/temp
__ Supervised play
__ Electrical injury
__ Passive smoking
__ Parent/infant interaction
__ Social interaction
__ Limit TV
__ Set limits
__ Sibling rivalry
__ Toilet training

Health Promotion
__ Immunizations
__ Smoking in home
__ Well-child care
__ Dental care, appointment
__ Family planning
__ Daycare

Nutrition
__ Healthy diet/snacks
__ Iron-rich foods
__ Physical activity
__ Weaning
__ Off bottle by age 1

Behavior
__ Parent/infant interaction
__ Social interaction
__ Limit TV
__ Set limits

Assessment

Plan

Dental referral made: Y N
WIC: Referred Refused N/A
Immunizations: Up to date To be given today Deferred
Explain:
Lab:
Hct/Hgb Lead
Hep C (if 12 months old or older and born to HCV infected woman)

Next appointment:

Date: Signature/Title: Signature/Title:
13 Months–2 Years
If used for documentation: ____________________________________
Patient’s Name: ____________________________________________
Date: _____________________________________________________

Key Elements

**Systems Review**

Skin: Rashes, infections
Eyes: Eye discharge, deviation, wandering eye movement
Ears: Hearing or ear problems
Nose/Mouth/Throat/Teeth: Nasal congestion
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

**Mental Health**

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Angry, sad, fearful, sullen, anxious, cries excessively or too little
Behavior: Overactivity, listlessness, harms others, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

**Progress Notes**

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C.10 Child Health Record (3-5 Years) (2 Pages)

**Family Profile and Health**

No change in household since last visit

Child lives with:
- Mother
- Father
- Stepparent
- Grandparent
- Other

Total adults living in home: ____________________________
Total children living in home: ____________________________
Primary caretaker for this child: ____________________________

**Development**

Parent's concerns:

Developmental Screening: P F
Type of Developmental Screen: Standardized Parent Questionnaire: ____________
Standardized Observational Screen: ____________
Other: ____________

Further assessment needed: Y N

**Child's Health**

Allergies:
Does the system review note any problems or parent concerns: Y N

Explain:
Major illness, injury, hospitalization, surgery (since last visit): ____________

Medications taken regularly — Type/Reason:

Dental Care:

**Physical Examination**

Temp _________ Pulse ____________ Resp ____________
BP _________ Height _________ Weight _________
(%) _________ (%) _________ (%) _________

**Assessment**

Dental referral made: Y N
WIC: ____________ Referred ____________ Refused ____________ N/A
Immunizations: Up to date ____________ To be given today ____________ Deferred ____________

Explain:
Lab:
Hct/Hgb _________ Lead _________

Next appointment:

Date: ____________ Signature/Title: ____________________________

**Nutrition**

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental

*If answered yes, further assessment needed.

Usual Servings Per Day:
- Dairy
- Vegetables
- WIC: Y N
- Breads, cereal, rice, and pasta
- Flouride Supplements: Y N
- Meat, poultry, fish, eggs, and dry beans
- Fruits
- Vitamins: Y N

**Sensory**

Vision Screen:
- Normal
- Abnormal

Hearing Screen:
- Normal
- Abnormal

Hearing Screen Used:
- Hearing Checklist for Parents

**Health Education**

Injury Prevention:
- Car safety restraints
- Poisoning
- Fire safety
- Firearms
- Street, water, bicycle safety
- Scissors/sharp objects
- Stranger safety
- Teach telephone no. & address
- Self-safety
- Passive smoking

Behavior:
- Talk/read with child
- Exploration
- Limit television
- Discipline, consistency

Nutrition:
- Healthy diet/snacks
- Junk food
- Iron-rich foods
- Physical activity

**Plan**

Dental referral made:
WIC: Referred Refused N/A
Immunizations: Up to date To be given today Deferred
Explain:
Lab:
Hct/Hgb Lead

Next appointment:
Appendix C

3–5 Years
If used for documentation: ____________________________
Patient’s Name: __________________________________________
Date: _____________________________________________________

Key Elements

Systems Review

Skin: Rashes, infections
Eyes: Eye discharge, blinking, tearing
Ears: Hearing or ear problems
Nose/Mouth/Throat/Teeth: Nasal congestion
Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency, soiling
Genitourinary: Dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.
Feelings: Out of control, angry, sad, fearful, sullen, anxious
Behavior: Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, self-abuses
Social Interaction: Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally
Thinking: Mistrustful, distracted, easily frustrated
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Progress Notes

_________________________________________________________________________________________
_________________________________________________________________________________________
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_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
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_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
C.11 Child Health Record (6-10 Years) (2 Pages)

**Family Profile and Health**
- **No change in household since last visit**
- **Child lives with:**
  - Mother
  - Father
  - Stepparent
  - Grandparent
  - Other
- **Total adults living in home:**
- **Total children living in home:**
- **Primary caretaker for this child:**
- **Relationship:**
- **Family's concerns/problems:**

**Mental Health**
- (+ indicates need for further assessment)
  - Sleep Problems
  - Special education classes
  - Behavior/problems
  - No/excessive extracurricular activities
  - Relationship problems with parents, siblings, peers
  - Substance abuse/use
  - Problems in school
  - Self-concept problems
  - Grade Level

**Child's Health**
- **Allergies:**
  - Does the system review note any problems or parent concerns:
  - Y
  - N
  - Explain:
  - Major illness, injury, hospitalization, surgery (since last visit):

**Dental Care/sealants:**
- Medications taken regularly — Type/Reason:

**Physical Examination**
- **Temp**
- **Pulse**
- **Resp**
- **BP**
- **Height**
- **Weight**
  - (%)
  - (%)
  - (%)

**Neurologic:**
- Appearance
  - Head/forehead
  - Skin/nodes
  - Eyes
  - Ears
  - Nose
  - Mouth/throat
  - Teeth

**Health Education**
- **Assessment**
  - Communication/conflict resolution

**Injury Prevention**
- **Seat belt/auto safety**
  - Bicycles/ATV
  - Athletics
  - Water safety
  - Smoke detectors
  - Firearm safety

**Behavior**
- **Substance abuse**
  - Tobacco use
  - Security
  - Discipline patterns
  - Responsibility

**Nutrition**
- **Problems:**
  - Special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group
  - Y
  - N

  - If answered yes, further assessment needed.

  - Usual Servings Per Day:
    - Dairy
    - Vegetables
    - Fruits
    - Breads, cereal, rice, and pasta
    - Meat, poultry, fish, eggs, and dry beans

**Sensory**
- **Vision Screen:**
  - Normal
  - Abnormal

- **Hearing Screen:**
  - Normal
  - Abnormal

- **Screen used:**
  - Hearing Checklist for Parents

**Plan**
- **Dental referral made:**
  - Y
  - N

- **Immunizations:**
  - Up to date
  - To be given today
  - Deferred

  - Explain:

  - **Lab:**
    - Hct/Hgb
    - Lead

  - **Next appointment:**

Date: ____________________ Signature/Title: ____________________ Signature/Title: ____________________
**Key Elements**

<table>
<thead>
<tr>
<th>Systems Review</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skin:</strong></td>
<td>Rashes, infections</td>
</tr>
<tr>
<td><strong>Ears:</strong></td>
<td>Hearing or ear problems</td>
</tr>
<tr>
<td><strong>Cardio/respiratory:</strong></td>
<td>History of murmur, trouble with breathing, wheezing</td>
</tr>
<tr>
<td><strong>Gastrointestinal:</strong></td>
<td>Bowel movement frequency, problems/concerns, encopresis</td>
</tr>
<tr>
<td><strong>Genitourinary:</strong></td>
<td>Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis</td>
</tr>
<tr>
<td><strong>Neuromuscular:</strong></td>
<td>Seizures</td>
</tr>
<tr>
<td><strong>Musculoskeletal:</strong></td>
<td>Fractures, sprains, sport injuries</td>
</tr>
</tbody>
</table>

**Progress Notes**

_________________________________________________________________________________________
_________________________________________________________________________________________
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_________________________________________________________________________________________
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_________________________________________________________________________________________
_________________________________________________________________________________________
# Hearing Checklist for Parents

## Client Information

Name: 

DOB: _______ / _______ / _______  Age: _______  Sex: _______

SSN/Record No.: 

Race/Ethnicity: 

Informant/Relationship: 

Medical Home: 

## Hearing Checklist for Parents

<table>
<thead>
<tr>
<th>Age 0 to 3 Yrs</th>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 3 months</td>
<td></td>
<td></td>
<td>Does your baby get quiet for a moment when you talk to him/her?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your baby act startled or stop moving for a moment when there are sudden loud noises?</td>
</tr>
<tr>
<td>4 to 6 months</td>
<td></td>
<td></td>
<td>Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your baby smile or stop crying when you or someone else he/she knows speaks?</td>
</tr>
<tr>
<td>7 to 9 months</td>
<td></td>
<td></td>
<td>Does your baby stop and pay attention when you say “no” or call his/her name?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your baby move his/her head around to try and find out where a new sound is coming from?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your baby make strings of sounds (“ba ba ba, da da da”)?</td>
</tr>
<tr>
<td>10 to 15 months</td>
<td></td>
<td></td>
<td>Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your baby point to familiar objects if you ask (“dog,” “light”)?</td>
</tr>
<tr>
<td>16 to 24 months</td>
<td></td>
<td></td>
<td>Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Can your child go get familiar objects that are kept in a regular place if you ask him/her (“Get your shoes.”)?</td>
</tr>
<tr>
<td>25 to 36 months</td>
<td></td>
<td></td>
<td>Does your child answer different kinds of questions (“When..., “Who..., “What...,”)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does your child notice different sounds (telephone ringing, shouting, doorbell)?</td>
</tr>
</tbody>
</table>

If you answered “no” to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

## Date of visit  Age  Result  Signature of Provider

| / | / |  |  |
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| / | / |  |  |

Department of State Health Services
Publication No. EFO5-12234 8/05
**C.13  Hearing Checklist for Parents (Spanish)**

**Lista de comprobación de audición para los padres**

<table>
<thead>
<tr>
<th>Edad</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>De 0 a 3 años</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>De 0 a 3 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su bebé se tranquiliza por un momento cuando le habla?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su bebé actúa sorprendido o deja de moverse por un momento cuando hay ruidos fuertes repentinos?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>De 4 a 6 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su bebé dirige la mirada o gira la cabeza hacia el sonido de su voz si no la está viendo?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su bebé sonríe o deja de llorar cuando le habla usted u otra persona que él conoce?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>De 7 a 9 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su bebé deja de hacer lo que está haciendo y pone atención cuando le dice &quot;no&quot; o lo llama por su nombre?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su bebé gira la cabeza hacia todos lados y trata de encontrar de dónde viene algún sonido nuevo?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su bebé hace sonidos repetidos (&quot;gu-gú, da-dá&quot;)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>De 10 a 15 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su bebé le da a usted juguetes u otros objetos (la botella) cuando se los pide, sin tener que usar gestos (extender la mano o señalar)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su bebé señala con el dedo objetos familiares si se lo pide (&quot;el perro&quot;, &quot;la luz&quot;)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>De 16 a 24 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su hijo usa principalmente la voz para conseguir lo que quiere o cuando quiere comunicarse con usted?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su hijo puede ir a buscar objetos familiares guardados en lugares regulares si usted se lo pide (&quot;Vé por tus zapatos&quot;)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>De 25 a 36 meses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su hijo responde a diferentes tipos de preguntas (&quot;Cuándo&quot;, &quot;Quién&quot;, &quot;Qué&quot;)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>¿Su hijo distingue sonidos diferentes (el timbre del teléfono, gritos, el timbre de la puerta)?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Si contestó "No" a cualquiera de las preguntas anteriores pida a su médico un examen auditivo para su bebé. Se puede examinar a los bebés tan pronto como el día de su nacimiento.

---

**Información del cliente**

Nombre: _______________________________________________________________________
Fecha de Nac.: / / Edad: ____________ Sexo: ____________
No. de SS/Expediente: ____________________________
Raza o etnicidad: ________________________________________________
Informante/Parentesco: _____________________________________________
Médico personal: _____________________________________________________

---

**Fecha de la visita** | **Edad** | **Resultado** | **Firma del proveedor**
--- | --- | --- | ---
/ / | / / | / / | / /
C.14 Mental Health Interview Tool/ Referral Form (Ages 0-2 Years)

### Mental Health Interview Tool/ Referral Form

**Ages 0 to 2**

For this age group you will obtain information from the parent/caregiver and from your own observations of the child. Circle items of concern. *The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

#### Feelings: Does your child display feelings that concern you or seem out of the ordinary?

- Infants
  - Anxious
  - Cries excessively
  - Cries too little

- 1 to 2 Years
  - Anxious
  - Crying
  - Sad

#### Behavior: Does your child display behavior that concerns you or seems out of the ordinary for his/her age?

- Infants
  - Overactive
  - Listlessness

- 1 to 2 Years
  - Overactive
  - Listlessness

#### Social Interaction: Do you have concerns about how your child gets along with you? Other family members or adults? Siblings?

- Infants
  - No eye contact or smile
  - Stiffens and arches
  - Not responsive

- 1 to 2 Years
  - *No eye contact or smile
  - Clings excessively
  - Not responsive
  - Language delay

#### Thinking: Do you think your child’s development is normal for age?

- Infants (≥ 8 months)
  - No communication skills (pointing to request an object) or efforts to make words

- 1 to 2 Year
  - Mistrustful
  - Problems concentrating or paying attention

#### Physical Problems: Do you have any concerns about your child’s physical health? If physical problems exist, have they been medically evaluated?

- Infants to 2 Years
  - Low weight or weight loss
  - Frequent vomiting
  - Eating problem (poor appetite, eats nonfoods)
  - Sleeping problem (frequent night waking)
  - Lethargic

#### Other:

Are there any situations which are causing your family particular stress at this time?

- Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse?
- If yes, what form, when, treatment initiated, etc.?
- Did the mother of this child use drugs or drink alcohol during the pregnancy?

#### Comments:

**Signature/ Title:** ________________________________

---

*THSteps Forms*
C.15 Mental Health Interview Tool/ Referral Form (Ages 3-9 Years)

**Mental Health Interview Tool/ Referral Form**

**Ages 3 to 9**

For this age group you will obtain information from the parent/caregiver and from your own observations of the child’s behavior. If possible, interview the parent alone when asking questions about sexual or physical abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.

### Feelings:

Does your child display feelings that concern you or seem out of the ordinary for age?

- ☐ Restless
- ☐ Sad or cries easily
- ☐ Excessively guilty
- ☐ Lack of remorse
- ☐ Irritable, angers or temper tantrums easily
- ☐ Sullen
- ☐ Fearful or anxious

### Behavior:

Does your child frequently display behavior that seems out of the ordinary for age?

- ☐ Problems in school
- ☐ * Harms other children or animals
- ☐ Lacks interest in things s/he used to enjoy
- ☐ Engages in sexual play with others, toys, animals
- ☐ * Destroys possessions or other property
- ☐ Steals
- ☐ Refuses to talk
- ☐ * Sets fires
- ☐ Overactive
- ☐ * Self-destructive
- ☐ * Has been in trouble with the police (older child)

### Social Interaction:

Do you have concerns about how child gets along with you, other family members, playmates, other adults?

- ☐ Withdraws including no eye contact
- ☐ Clings excessively
- ☐ Difficulty making and keeping friends
- ☐ Defiant, a discipline problem
- ☐ Severe or frequent tantrums
- ☐ Aggressive
- ☐ Argues excessively
- ☐ Refuses to go to school
- ☐ Prefers to be alone

### Thinking:

Have you noticed any of the following to be a problem for your child?

- ☐ * Frequently confused
- ☐ Daydreams excessively
- ☐ Distracted, doesn’t pay attention
- ☐ * Bizarre thoughts
- ☐ Mistrustful
- ☐ * Sees or hears things that are not there (excluding imaginary friends in younger children)
- ☐ Blames others for his/her misdeeds or thoughts
- ☐ * Talks about death
- ☐ * Frequent memory loss
- ☐ Schoolwork is slipping (grades going down)

### Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ☐ Daytime wetting
- ☐ Soils pants
- ☐ Refusal to eat
- ☐ Headaches
- ☐ Excessive weight loss or gain
- ☐ Sleep problems, nightmares, sleep-walking, early waking
- ☐ Vomits frequently
- ☐ Frequent stomachaches
- ☐ Lacks energy

### Other:

Is this child accident-prone? Are there any situations that are causing your family particular stress? Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc. * Is this child at risk for out-of-home placement because of behavior problems?

Comments:

---

**Signature/ Title: ____________________________
C.16 Mental Health Interview Tool/Referral Form (Ages 10-12 Years)

Mental Health Interview Tool/Referral Form

Ages 10 to 12

Both child and parent will be able to provide information, and it is important to incorporate the child into the interview process. In each section, a sample question is directed toward the parent. To the extent possible, elicit the child’s perception of the parent’s response with a question such as “Do you agree with what your Mom is saying?” It may be useful to allow time for discussion with the caregiver alone. The child should be interviewed alone when asking questions about sexual or physical abuse and about substance abuse. Circle items of concern.

* The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.

Feelings:

Does your child (do you) have feelings that concern you or seem out of the ordinary for age?

- Restless
- Sad or cries easily
- Guilty
- Irritable or angers easily
- Sullen
- Fearful or anxious
- Bored

Behavior:

Does your child (do you) behave in ways that seem out of the ordinary for age?

- Problems in school
- * Threatens or harms other children or animals
- Lacks interest in things s/he used to enjoy
- Engages in sexual play with others, toys, animals
- * Destroys possessions or other property
- Steals
- Refuses to talk
- * Sets fires
- Overactive
- * Has been in trouble with the police
- * Self-destructive

Social Interaction:

Do you have concerns about how your child (you) gets along with family members, other adults or children?

- Prefers to be alone
- Difficulty making and keeping friends
- Defiant, a discipline problem
- Aggressive
- Argues excessively
- Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for your child (you)?

- * Frequently confused
- Daydreams excessively
- Distracted, doesn’t pay attention
- Mistrustful
- * Sees or hears things that are not there
- Blames others for his/her misdeeds or thoughts
- * Talks about death or suicide
- * Frequent memory loss
- * Bizarre thoughts
- Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- Lacks energy
- Uses laxatives
- Vomits frequently
- Food refusal, secretive eating
- Frequent stomachaches
- Headaches
- Excessive weight loss or gain
- Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Is this child (are you) accident-prone?

Are there any situations that are causing your family particular stress?

Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- * Is this child at risk for out-of-home placement because of behavior problems?
- Has the child (have you) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- Has been identified as a problem

Comments:

Signature/Title: ____________________________________________________________

C.16 Mental Health Interview Tool/Referral Form (Ages 10-12 Years)
C.17  Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

**Mental Health Interview Tool/Referral Form**

**Child’s Name:** __________________________

**Birth Date:** __________________________

**Date:** __________________________

You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.

### Feelings:
Do you (does your teen) have feelings that concern you or seem out of the ordinary for (their) age?

- Restless
- Sad or cries easily
- Guilty
- Irritable or angers easily
- Sullen
- Fearful or anxious
- Bored

### Behavior:
Do you (does your child) behave in ways that seem out of the ordinary for (their) age?

- Problems at school or work
- * Threatens or harms other children or animals
- Lacks interest in things s/he used to enjoy
- Engages in sexual play with others, toys, animals
- * Destroys possessions or other property
- Steals
- Refuses to talk
- * Sets fires
- Overactive
- * Has been in trouble with the police
- * Self-destructive

### Social Interaction:
Do you have concerns about how (you) your child gets along with family members, other adults, or peers?

- Prefers to be alone
- Difficulty making and keeping friends
- Defiant, a discipline problem
- Aggressive
- Argues excessively
- Refuses to go to school

### Thinking:
Have you noticed any of the following to be a problem for you (your child)?

- * Frequently confused
- Daydreams excessively
- Distracted, doesn’t pay attention
- Mistrustful
- * Sees or hears things that are not there
- Blames others for his/her misdeeds or thoughts
- * Talks about death or suicide
- * Frequent memory loss
- * Bizarre thoughts
- Schoolwork is slipping (grades going down)

### Physical Problems:
Do you have any concerns about the following physical signs? Has this been evaluated?

- Lacks energy
- Uses laxatives
- Vomits frequently
- Food refusal, secretive eating
- Frequent stomachaches
- Headaches
- Excessive weight loss or gain
- Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

### Other:
Are you (is this child) accident-prone?
Are there any situations that are causing your family particular stress? Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- * Are you (is this child) at risk for out-of-home placement because of behavior problems?
- Have you (has this child) been treated for mental health problems or substance abuse?

### Substance Abuse Questions:
(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- Has been identified as a problem

**Comments:**

**Signature/Title:** _______________________________________________________________

---

Appendix C
C.18 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)

Mental Health Parent Questionnaire
Ages Birth to 2 Years

| Child’s Name: | ______________________________ |
| Birth Date: | ______________________________ |
| Today’s Date: | ______________________________ |

To the Parent: If you will assist us by filling out this form, we can help you find your child’s strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.

### Feelings

<table>
<thead>
<tr>
<th>Infants</th>
<th>1 to 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Fearful</td>
<td>❑ Is irritable</td>
</tr>
<tr>
<td>❑ Cries too much</td>
<td>❑ Is angry</td>
</tr>
<tr>
<td>❑ Cries too little</td>
<td>❑ Is sad</td>
</tr>
<tr>
<td>❑ Is sullen</td>
<td>❑ Cries too much</td>
</tr>
</tbody>
</table>

### Behavior

<table>
<thead>
<tr>
<th>Infants</th>
<th>1 to 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Is overactive</td>
<td>❑ Is overactive</td>
</tr>
<tr>
<td>❑ Is listless (has little energy)</td>
<td>❑ Has temper tantrums often</td>
</tr>
</tbody>
</table>

### Social Interaction

<table>
<thead>
<tr>
<th>Infants</th>
<th>1 to 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Does not make eye contact or smile</td>
<td>❑ Does not make eye contact or smile</td>
</tr>
<tr>
<td>❑ Stiffens and arches back</td>
<td>❑ Does not respond to you</td>
</tr>
<tr>
<td>❑ Does not respond to you</td>
<td>❑ Clings to you too much</td>
</tr>
</tbody>
</table>

### Thinking

<table>
<thead>
<tr>
<th>Infants</th>
<th>1 to 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ (&gt;8 months) Does not point to or ask for things or try to make words</td>
<td>❑ Does not trust others</td>
</tr>
<tr>
<td></td>
<td>❑ Has problems concentrating or paying attention</td>
</tr>
<tr>
<td>Physical Concerns</td>
<td>Question</td>
</tr>
<tr>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Do you have any concerns about these things?</td>
<td>Yes</td>
</tr>
<tr>
<td>If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem?</td>
<td>Yes</td>
</tr>
<tr>
<td>Infants to 2 Years</td>
<td></td>
</tr>
<tr>
<td>Is low weight or has a lot of weight</td>
<td></td>
</tr>
<tr>
<td>Vomits (throws up) often</td>
<td></td>
</tr>
<tr>
<td>Has eating problems</td>
<td></td>
</tr>
<tr>
<td>(poor appetite, eats non-foods)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Question</td>
</tr>
<tr>
<td>Is anything causing your family stress right now?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? When?</td>
<td>Yes</td>
</tr>
<tr>
<td>Treatment initiated?</td>
<td>Yes</td>
</tr>
<tr>
<td>Did the mother of this child use drugs or alcohol during the pregnancy?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Comments: *(Please write anything else you want us to know about in this space.)*

Date: __________  Signature: ________________________________

Relation to patient: ________________________________
C.19 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish)

**Cuestionario de la Salud Mental para los Padres**

Nombre del Niño: ____________________________
Fecha de Nacimiento: ____________________________
Fecha: ____________________________

De Recién Nacido a 2 Años de Edad

Para los Padres: Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su bebé. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su bebé. Favor de marcar todas las características abajo que son ciertas para su bebé. Algunos de los comportamientos en las listas tal vez sean normales, pero sí usted está preocupado, favor de informarnos.

<table>
<thead>
<tr>
<th>SENTIMIENTOS</th>
<th>Bebés</th>
<th>De 1 a 2 Años</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>Siente miedo</td>
<td>❑</td>
<td>❑ Siente miedo</td>
</tr>
<tr>
<td>Lloora mucho</td>
<td>❑</td>
<td>❑ Lloora muy poco</td>
</tr>
<tr>
<td>Lloora muy poco</td>
<td>❑</td>
<td>❑ Lloora mucho</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPORTAMIENTO</th>
<th>Bebés</th>
<th>De 1 a 2 Años</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Hace su bebé cosas que le preocupan o que parezcan extrañas para su edad?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>Es demasiado activo</td>
<td>❑</td>
<td>❑ Es demasiado activo</td>
</tr>
<tr>
<td>Es indiferente (tiene poca energía)</td>
<td>❑</td>
<td>❑ Es indiferente (tiene poca energía)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERACCIONES SOCIALES</th>
<th>Bebés</th>
<th>De 1 a 2 Años</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Se preocupa sobre cómo se lleva su bebé con usted?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>¿Con otros miembros de la familia o adultos?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>¿Con sus hermanos o hermanas?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>No ve a los ojos ni sonríe</td>
<td>❑</td>
<td>❑ No ve a los ojos ni sonríe</td>
</tr>
<tr>
<td>Se pone tieso y se dobla arqueando la espalda</td>
<td>❑</td>
<td>❑ La mayoría del tiempo no se le despega</td>
</tr>
<tr>
<td>No le responde</td>
<td>❑</td>
<td>❑ No le responde</td>
</tr>
<tr>
<td>Todavía no dice ninguna palabra</td>
<td>❑</td>
<td>❑ Todavía no dice ninguna palabra</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PENSAMIENTOS</th>
<th>Bebés</th>
<th>De 1 a 2 Años</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Piensa usted que su niño es tan inteligente y que piensa tan claramente como otros niños de su edad?</td>
<td>❑ Sí ❑ No</td>
<td></td>
</tr>
<tr>
<td>(&gt;8 meses) No pide ni salta a las cosas o trata de decir palabras</td>
<td>❑</td>
<td>❑ No le tiene confianza a otros</td>
</tr>
<tr>
<td>Tiene problemas para concentrarse y poner atención</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>PRBLEMAS</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema?</td>
<td>Sí</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEMAS</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Se preocupa usted sobre los siguientes problemas físicos?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>¿Has estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, en qué forma?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>¿Empezó el tratamiento?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño?</td>
<td>Sí</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEMAS</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>De recién nacidos a 2 Años</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Es de peso bajo o ha perdido mucho peso</td>
<td>Tiene problemas para dormir (se desperta mucho durante la noche)</td>
<td></td>
</tr>
<tr>
<td>Se vomiita frecuentemente</td>
<td>Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables)</td>
<td></td>
</tr>
<tr>
<td>Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables)</td>
<td>Tiene muy poca energía</td>
<td></td>
</tr>
</tbody>
</table>

Comentarios: (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)

Fecha: ___________  Firma: _____________________________

Parentesco con el paciente: _____________________________
C.20 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

Mental Health Parent Questionnaire

Child’s Name: ________________________
Birth Date: __________________________
Today’s Date: ________________________

To the Parent: If you will assist us by filling out this form, we can help you find your child’s strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.

**Feelings**

- [ ] Is restless
- [ ] Is sad or cries easily
- [ ] Is overly guilty
- [ ] Lacks remorse
- [ ] Is irritable, angers or temper tantrums easily
- [ ] Is sullen
- [ ] Fearful

**Behavior**

- [ ] Has problems in school
- [ ] Harms other children or animals
- [ ] Plays sexual games with others, toys, animals
- [ ] Destroys possessions or other property
- [ ] Steals
- [ ] Refuses to talk
- [ ] Sets fires
- [ ] Is over-active
- [ ] Hurts himself or herself
- [ ] Has been in trouble with the police

**Social Interaction**

- [ ] Withdraws and does not look into peoples’ eyes
- [ ] Clings to you too much
- [ ] Has a hard time making and keeping friends
- [ ] Is defiant, has a disciplinary problem
- [ ] Severe or frequent tantrums
- [ ] Picks on others a lot or often gets into fights (hitting, etc.)
- [ ] Argues too much
- [ ] Will not go to school
- [ ] Prefers to be alone

**Thinking**

- [ ] Is frequently confused (does not understand what is going on)
- [ ] Daydreams a lot
- [ ] Is distracted, doesn’t pay attention
- [ ] Has very strange thoughts
- [ ] Schoolwork is slipping (grades going down)
- [ ] Does not trust others
- [ ] Sees or hears things that are not there
- [ ] Blames others for his/her misdeeds or thoughts
- [ ] Talks about death a lot
- [ ] Often cannot remember things
## Physical Problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has daytime wetting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soils pants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will not eat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has lost or gained a lot of weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has sleeping problems, nightmares, sleep-walking, early waking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomits (throws up) often</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has stomach aches often</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacks energy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other

- Is this child accident-prone? [ ] Yes [ ] No
- Is anything causing your family stress right now? [ ] Yes [ ] No
- Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________________ When? ________ [ ] Yes [ ] No
- Treatment initiated? [ ] Yes [ ] No
- Is this child at risk for out-of-home placement because of behavior problems? [ ] Yes [ ] No

## Comments:

(Please write anything else you want us to know about in this space.)

---

**Date:** ____________  **Signature:** ____________________________________________________________

**Relation to patient:** ____________________________________________________________
## C.21 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

**Questionario de la Salud Mental para los Padres De 3 a 9 Años de Edad**

Para los Padres: Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su niño. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que sean ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.

<table>
<thead>
<tr>
<th>SentiMienTos</th>
<th>¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Es inquieta</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Es triste o llora fácilmente</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se siente muy culpable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● No tiene remordimiento</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Es de mal carácter, enojón o hace berrinches temperamentales fácilmente</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Es malhumorado</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Siente miedo</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comportamiento</th>
<th>¿Hace su niño cosas que le parezcan extrañas para su edad?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Tiene problemas en la escuela</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Lastima a otros niños o a los animales</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● No le interesan las cosas que antes le gustaban</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Juega juegos sexuales con otros niños, juguetes, o animales</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Destructuye cosas personales u ajenas</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Roba</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se niega a hablar</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Provoca incendios</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Es demasiado activo</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se lastima</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Ha tenido problemas con la policía</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interacciones</th>
<th>¿Se preocupa sobre cómo se lleva su niño con usted?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>¿Con otros miembros de la familia o adultos?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>¿Con sus compañeros de juego?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se aleja y no ve a nadie a los ojos</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● La mayoría del tiempo no se le despega</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se le dificulta hacer y mantener amistades</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Es desafiante, tiene un problema de disciplina</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Hace berrinches temperamentales fuertes o frecuentemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Discute mucho</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● No quiere asistir a la escuela</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Prefiere estar solo</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pensamientos</th>
<th>¿Son algunas de estas características un problema para su niño?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Se confunde frecuentemente (no entiende lo que está pasando)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Sueña mucho desperto</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se distrae, no pone atención</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Tiene pensamientos muy extraños</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Se está atravesando en el trabajo de la escuela (sus grados están bajando)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● No le tiene confianza a los demás</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Mira u oye cosas que no están allí</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Culpa a otros por algo que hizo mal o por sus pensamientos</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Habla mucho sobre la muerte</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Frecuentemente no se acuerda de cosas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROBLEMAS FÍSICOS</td>
<td>PROBLEMAS OTRAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Se preocupa usted sobre los siguientes problemas físicos?</td>
<td>¿Es propenso este niño a tener accidentes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sí usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema?</td>
<td>¿Hay algo que le está causando tensión a su familia ahora?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Se orina durante el día</td>
<td>— Ha estado este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Ensucia sus pantalones</td>
<td>— Sí, ¿en qué forma? — ¿Cuándo? ¿Empezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— No quiere comer</td>
<td>— Ha perdido o aumentado mucho de peso</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Tiene dolores de cabeza</td>
<td>— Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Tiene dolores de estómago frecuentemente</td>
<td>— Se vomita frecuentemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— No tiene energía</td>
<td>— Tiene dolores de estómago frecuentemente</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comentario: (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)

Fecha: ___________ Firma: ________________________________________________

Parentesco con el paciente: ____________________________________________
C.22 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages)

**Mental Health Parent Questionnaire**

**Child’s Name: ____________________________**

**Birth Date: ______________________________**

**Today’s Date: _____________________________**

To the Parent: *If you will assist us by filling out this form, we can help you find your child’s strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Does your child (do you) show feelings that concern you or seem strange for their (your) age?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Is restless</td>
<td>□ Is rotten</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is sad or cries easily</td>
<td>□ Is sullen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is guilty</td>
<td>□ Is fearful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is irritable or anger easily</td>
<td>□ Is bored</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Does your child (do you) often do things that seem strange for their (your) age?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Has problems in school</td>
<td>□ Refuses to talk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Threatens or harms other children or animals</td>
<td>□ Sets fires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Lacks interest in things s/he used to enjoy</td>
<td>□ Is overactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is involved in sexual activity</td>
<td>□ Hurts himself or herself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Destroys possessions or other property</td>
<td>□ Has been in trouble with the police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Steals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social interaction</th>
<th>Do you have any concerns about how your child (you) get(s) along with family members?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With other adults? □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With other children? □ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Prefers to be alone</td>
<td>□ Picks on others a lot or often gets into fights (hitting, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Has a hard time making and keeping friends</td>
<td>□ Argues too much</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is defiant, a disciplinary problem</td>
<td>□ Will not go to school</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thinking</th>
<th>Are any of these a problem for your child (you)?</th>
<th>☐ Yes</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Is frequently confused (does not understand what is going on)</td>
<td>□ Does not trust others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Daydreams a lot</td>
<td>□ Sees or hears things that are not there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Is distracted, doesn’t pay attention</td>
<td>□ Blames others for his/her misdeeds or thoughts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Has very strange thoughts</td>
<td>□ Talks about death or suicide a lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Schoolwork is slipping (grades going down)</td>
<td>□ Often cannot remember things</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix C

### Physical Problems

- Do you have any concerns about these things?  
  - Yes  
  - No
- If you think your child (you) may have a health problem, has he/she (have you) seen a doctor or nurse about the problem?  
  - Yes  
  - No
- Lacks energy  
- Uses laxatives  
- Vomits (throws up) often  
- Won’t eat in front of people, sneaks food later  
- Has stomach aches often  
- Has headaches  
- Has lost or gained a lot of weight  
- Has sleeping problems, nightmares, sleep-walking, early waking, frequent night waking

### Other

- Is your child (you) accident-prone?  
  - Yes  
  - No
- Is anything causing your family stress right now?  
  - Yes  
  - No
- Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from?  
  - When?  
  - Yes  
  - No
- Treatment initiated?  
  - Yes  
  - No
- Is this child (are you) at risk for out-of-home placement because of behavior problems?  
  - Yes  
  - No
- Does your child (do you) drink of use drugs (including street or over-the-counter)?  
  - Yes  
  - No
- Has this child (have you) been treated for mental health problems or substance abuse?  
  - Yes  
  - No

### Comments:

(Please write anything else you want us to know about in this space.)

---

Date: ____________  
Signature:  
Relation to patient: 

CPT only copyright 2008 American Medical Association. All rights reserved.
### C.23 Mental Health Parent Questionnaire (Ages 10-12 Years) (2 Pages) (Spanish)

**Questionario de la Salud Mental para los Padres**
**De 10 a 12 Años de Edad**

Para los Padres: Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su hijo. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que son ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.

<table>
<thead>
<tr>
<th><strong>Sentimientos</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Es inquieto</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Es triste o llora fácilmente</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se siente culpable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Es de mal carácter o se enojá fácilmente</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Es malhumorado</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Siente miedo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se aburre</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Comportamiento</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Hace su niño cosas que le parezcan extrañas para su edad?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Tiene problemas en la escuela</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amenaza o lastima a otros niños o a los animales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No le interesan las cosas que antes le gustaban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participa en actividades sexuales</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Destructe cosas personales o ajenas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roba</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se niega a hablar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provoca incendios</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Es demasiado activo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se lastima</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ha tenido problemas con la policía</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interacciones Sociales</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Se preocupa sobre cómo se lleva su niño con usted?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>¿Con otros adultos?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>¿Con otros niños?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Prefiere estar solo</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se le dificulta hacer y mantener amistades</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Es desafiante, tiene un problema de disciplina</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discute mucho</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No quiere asistir a la escuela</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pensamientos</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Son algunas de estas características un problema para su niño?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Se confunde frecuentemente (no entiende lo que está pasando)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sueña mucho despierto</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se distrae, no pone atención</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tiene pensamientos muy extraños</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Se está abrazando en el trabajo de la escuela (sus grados están bajando)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No le tiene confianza a los demás</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mira u oye cosas que no están allí</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culpa a otros por algo que hizo mal o por sus pensamientos</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habla mucho sobre la muerte o del suicidio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frecuentemente no se acuerda de cosas</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix C

#### Problemas físicos

<table>
<thead>
<tr>
<th>Problema</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>La falta de energía</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usa laxantes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se vuelve frecuentemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No come delante de la gente, come después de escondidas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene dolores de estómago frecuentemente</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Otros

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Es propenso a tener accidentes su niño?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Hay algo que le está causando tensión a su familia ahora?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Ha sido este niño o sus padres sujetos a la negligencia o abuso físico, sexual o emocional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Si, ¿en qué forma? ¿Cuándo?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Empiezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Cómo este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Toma bebidas alcohólicas o usa drogas su niño (incluyendo las de la calle y las que se venden sin receta)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancias como las drogas y bebidas alcohólicas?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comentario:** (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)

---

Fecha: __________  Firma: ____________________________

Parentesco con el paciente: ____________________________
C.24 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 13 to 20 Years

To the Teen or Parent: If you will assist us by filling out this form, we can help you find your (your teen's) strengths and any problem areas, too. Your answers will help us to know if we need to talk with you (your teen) and find out more about you (your teen). Please check all items below that are true for you (your teen). Some of the behaviors noted may be normal but if you are concerned please let us know.

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Restless</td>
<td>❑ Sullen</td>
<td></td>
</tr>
<tr>
<td>❑ Sad or cry easily</td>
<td>❑ Fearful</td>
<td></td>
</tr>
<tr>
<td>❑ Guilty</td>
<td>❑ Bored</td>
<td></td>
</tr>
<tr>
<td>❑ Irritable or angered easily</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Have problems in school or work</td>
<td>❑ Refuse to talk</td>
<td></td>
</tr>
<tr>
<td>❑ Threaten or harm other children or animals</td>
<td>❑ Set fires</td>
<td></td>
</tr>
<tr>
<td>❑ Lack interest in things you used to enjoy</td>
<td>❑ Over-active</td>
<td></td>
</tr>
<tr>
<td>❑ Is involved in sexual activity</td>
<td>❑ Hurt yourself</td>
<td></td>
</tr>
<tr>
<td>❑ Destroy possessions or other property</td>
<td>❑ Have been in trouble with the police</td>
<td></td>
</tr>
<tr>
<td>❑ Steal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Action</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Prefer to be alone</td>
<td>❑ Pick on others a lot or often get into fights (hitting, etc.)</td>
<td></td>
</tr>
<tr>
<td>❑ Have a hard time making and keeping friends</td>
<td>❑ Argue too much</td>
<td></td>
</tr>
<tr>
<td>❑ Defiant, a disciplinary problem</td>
<td>❑ Will not go to school</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thinking</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Frequently confused (does not understand what is going on)</td>
<td>❑ Do not trust others</td>
<td></td>
</tr>
<tr>
<td>❑ Daydream a lot</td>
<td>❑ See or hear things that are not there</td>
<td></td>
</tr>
<tr>
<td>❑ Distracted, do not pay attention</td>
<td>❑ Blame others for your misdeeds or thoughts</td>
<td></td>
</tr>
<tr>
<td>❑ Have very strange thoughts</td>
<td>❑ Talk about death or suicide a lot</td>
<td></td>
</tr>
<tr>
<td>❑ Schoolwork is slipping (grades going down)</td>
<td>❑ Often cannot remember things</td>
<td></td>
</tr>
</tbody>
</table>
### Physical Problems

<table>
<thead>
<tr>
<th>Problems</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use laxatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomit (throw up) often</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Won't eat in front of people, sneak food later</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have stomachaches often</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you (is your teen) accident-prone?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is anything causing your family stress right now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment initiated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you (is this teen) at risk for out-of-home placement because of behavior problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you (does your child) drink of use drugs (including street or over-the-counter)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you (has this teen) been treated for mental health problems or substance abuse?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

*(Please write anything else you want us to know about in this space.)*

---

Date: ___________  Signature: _____________________________________________

Relation to patient: ________________________________________________
Para los Padres: Si nos ayuda llenando este formulario, podremos ayudarte a encontrar las áreas fuertes que tenga su hijo y también cualquier área problemática. Sus respuestas nos ayudarán a saber si necesitamos hablar con su hijo y saber más sobre él. Favor de marcar todas las características abajo que son ciertas para su hijo. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.

<table>
<thead>
<tr>
<th>SENTIMIENTOS</th>
<th>¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Es inquieto</td>
</tr>
<tr>
<td></td>
<td>Es triste o llora fácilmente</td>
</tr>
<tr>
<td></td>
<td>Se siente culpable</td>
</tr>
<tr>
<td></td>
<td>Es irrita o enoja fácilmente</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPORTAMIENTO</th>
<th>¿Hace su hijo cosas frecuentemente que le parezcan extrañas para su edad?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tiene problemas en la escuela o en el trabajo</td>
</tr>
<tr>
<td></td>
<td>Amenaza o lastima a otros niños o a los animales</td>
</tr>
<tr>
<td></td>
<td>No le interesan las cosas que antes le gustaban</td>
</tr>
<tr>
<td></td>
<td>Está envuelto en actividades sexuales</td>
</tr>
<tr>
<td></td>
<td>Destroza cosas personales u otras cosas ajenas</td>
</tr>
<tr>
<td></td>
<td>Roba</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTERACCIONES</th>
<th>¿Le preocupa cómo se lleva su hijo con los miembros de la familia?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>¿Con otros adultos?</td>
</tr>
<tr>
<td></td>
<td>¿Con su grupo social?</td>
</tr>
</tbody>
</table>

|              | Prefiere estar solo                                              | Sí  | No |
|              | Se le dificulta hacer y mantener amistades                       | Sí  | No |
|              | Es desafiante, tiene un problema de disciplina                   | Sí  | No |

<table>
<thead>
<tr>
<th>PENSAMIENTOS</th>
<th>¿Son algunas de estas características un problema para su hijo?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Se confunde frecuentemente (no entiende lo que está pasando)</td>
</tr>
<tr>
<td></td>
<td>Sueña mucho despierto</td>
</tr>
<tr>
<td></td>
<td>Se distrae, no pone atención</td>
</tr>
<tr>
<td></td>
<td>Tiene pensamientos muy extraños</td>
</tr>
<tr>
<td></td>
<td>Se está atrasando en el trabajo de la escuela (sus grados están bajando)</td>
</tr>
</tbody>
</table>

|                | Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)   | Sí  | No |
|                | Discute mucho                                                   | Sí  | No |
|                | No quiere asistir a la escuela                                   | Sí  | No |

|                | No le tiene confianza a los demás                                 | Sí  | No |
|                | Mira u oye cosas que no están allí                                | Sí  | No |
|                | Culpa a otros por algo que hizo mal o por sus pensamientos       | Sí  | No |
|                | Habla mucho sobre la muerte o el suicidio                        | Sí  | No |
|                | Frecuentemente no se acuerda de cosas                            | Sí  | No |
### Problemas

<table>
<thead>
<tr>
<th>¿Se preocupa por estas cosas?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Si piensa que su hijo tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera por este problema?</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>No tiene energía</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Usa laxantes</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Se vomita frecuentemente</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>No come delante de la gente, come después a escondidas</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Tiene dolores de estómago frecuentemente</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Tiene dolores de cabeza</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Ha perdido o aumentado mucho peso</td>
<td>Sí</td>
<td>No</td>
</tr>
<tr>
<td>Tiene problemas para dormir, pesadillas, se despierta temprano, sonámbulo y frecuentemente despierta durante la noche</td>
<td>Sí</td>
<td>No</td>
</tr>
</tbody>
</table>

### Otros

| ¿Es su hijo propenso a tener accidentes? | Sí | No |
| ¿Hay algo que le está causando tensión a su familia ahora? | Sí | No |
| ¿Ha sido su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? | Sí | No |
| Si sí, ¿en qué forma? ¿Cuándo? | Sí | No |
| ¿Empezó el tratamiento? | Sí | No |
| ¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? | Sí | No |
| ¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)? | Sí | No |
| ¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o bebidas alcohólicas? | Sí | No |

**Comentario:** (Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)

---

Fecha: ____________  Firma: ____________________________________________________________

Parentesco con el paciente: ________________________________________________________

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NOTES to Healthcare Provider:

- This risk assessment questionnaire replaces, and should be used in place of, the Abbreviated and the Detailed Parent Questionnaires. Questions appear on reverse.
- The risk assessment questionnaire is designed to be administered to the parent by the provider. Questions are provided in English along with Spanish versions to assist with Spanish speaking parents.

Instructions:

- Medicaid requires a blood lead test at 12 months and 24 months for all Texas Health Steps patients. This questionnaire may be used with any child, whether or not enrolled in Texas Health Steps.
- At any visit, you may choose to perform a blood lead test rather than use the risk assessment questionnaire.
- At any visit after 12 months of age, you must administer a blood lead test if there is no evidence of a previous blood lead test for the patient.
- Refer to the table below for scheduling use of the risk assessment questionnaire.
- A "yes" or "don't know" answer to any question on the risk assessment questionnaire indicates that a blood lead test should be administered.

<table>
<thead>
<tr>
<th>Child's Age</th>
<th>Parent Questionnaire</th>
<th>Blood Lead Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>9 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>15 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>24 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>3, 4, 5, 6, years</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

For more information, contact the Texas Childhood Lead Poisoning Prevention Program at:
1-800-588-1248
http://www.dshs.state.tx.us/lead
# Appendix C

## Parent Questionnaire – Risk Assessment for Lead Exposure

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Don’t Know</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your child live in or often visit a home, daycare facility, or other building that was probably built before 1978?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- with ongoing repairs or remodeling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your child eat or chew on non-food things like paint chips or dirt?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Does your child reside in a household or has contact with an individual with an elevated blood lead level?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is your child frequently exposed to any of the following (if YES, check all that apply):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contamination from a parent, relative, or friend with jobs or hobbies like these?

- Radiator repair
- Pottery making
- Lead smelting
- Welding
- Making fishing weights
- Going to a firing range or reloading bullets
- Chemical preparation
- Battery manufacture or repair
- Burning lead-painted wood
- Automotive repair shop or junkyard
- Refinishing furniture
- Other:

### Sources of lead in food and remedies?

- Imported or glazed pottery such as a Mexican bean pot
- Imported candy, like Chaca Chaca especially from Mexico
- Nutritional pills other than vitamins
- Other:

### Cuestionario de Padre

<table>
<thead>
<tr>
<th>Question</th>
<th>Sí</th>
<th>No lo sé</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ¿Vive su hijo(a) en o visita frecuentemente una casa centro de guardería u otro edificio que probablemente haya sido construida antes de 1978?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- que esté siendo pintada, remodelada, o en la que están pelando o lijando la pintura?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ¿Han tenido parientes o compañeritos de juego de su hijo(a) altos niveles de plomo en la sangre?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ha sido expuesto frecuentemente su hijo(a) a cualquier de los siguientes (si SÍ, marque todos que apliquen): La haga al niño una prueba de plomo en el sangre</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estos?

- Reparación de radiadores
- Fabricación de cerámica
- Industria del plomo
- Soldadura
- Fabricación de pesas para pesar
- Construcción o reparación de casas
- Fabricación o reparación de baterías
- Quema de madera pintada con plomo
- Taller mecánico para autos o lote de chatarra
- Ir a un campo de tiro o recargar balas
- Preparación de químicos
- Partes sueltas para tubos de cañerías y válvulas
- Fundición de latón/cobre
- Terminado o de muebles
- Otros:

### Fuentes de plomo en comidas y remedios?

- Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México
- Productos enlatados o empacados fuera de los Estados Unidos
- Dulces importados, como Chaca Chaca especialmente de México
- Remedios tradicionales como greta, azarón, alarcón, alko hl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda
- Píldoras alimenticias con excepción de las vitaminas
- Otros:

---

Fax completed form to 512-458-7699, or mail to address below

Texas Childhood Lead Poisoning Prevention Program
Epidemiology & Surveillance Unit • Texas Department of State Health Services
PO BOX 149347 • Austin, TX 78714-9347  #Pb-110  05-22-08

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C.27 Tuberculosis (TB) Screening and Education Tool

This screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing. In areas of high TB prevalence, the screening tool need not be done at visits for which tuberculin skin testing is required: 1 year of age, once between 4 through 6 years of age, and once between 11 through 17 years of age.

The questions in this screening tool are intended as a minimum screen. Follow-up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child’s community may need to be added.

- If all the answers are unqualified negatives, the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is “Yes” or “I don’t know,” the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of “Yes” or “I don’t know” prompted a skin test, which was negative, the skin test may not have to be repeated annually.
- The decision to administer a skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- Bacillus of Calmette and Guérin (BCG) vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB.
- A chest X-ray to rule out active disease.
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present.
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present.
- A report to the local health authority for investigation to find the source of the infection.

Feel free to photocopy the screening and education tool from this publication.
C.28  TB Questionnaire

Name of Child____________________________________________________________Date of Birth ________________

Organization administering questionnaire______________________________________ Date_______________________

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

<table>
<thead>
<tr>
<th>Place a mark in the appropriate box:</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only

PPD administered Yes___ No___

If yes, Date administered _____/_____/______ Date read _____/_____/_______ Result of PPD test _______ mm response

Type of service provider (i.e. school, Health Steps, other clinics)

PPD provider ____________________________ signature

Provider phone number ____________________________

City ____________________________ County

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider ____________________________
C.29  Cuestionario Para la Detección de Tuberculosis

Nombre del niño o niña ________________________________________________________________

Organización _______________________________________________________ Fecha ___________________________

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoría de los casos es trasmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expulsar gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés).

La TB es prevenible y curable. La prueba tuberculínica, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculínica no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a a la tuberculosis.

<table>
<thead>
<tr>
<th></th>
<th>Sí</th>
<th>No</th>
<th>No se sabe</th>
</tr>
</thead>
</table>

La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si:

- su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas?
- su niño o niña ha tenido algunos de estos síntomas o problemas?
- su niño o niña ha estado cerca de alguna persona enferma de tuberculosis?

¿Su niño o niña nació en México o en cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia?

¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia durante el último año por más de 3 semanas?

Si su respuesta es positiva, favor de especificar a qué país o países.

¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos?

¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente? Sí (si sí, especifique la fecha ___/____) No__

¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí (si sí, especifique la fecha ___/____) No__

Solamente para uso de la escuela o del proveedor de servicios médicos

<table>
<thead>
<tr>
<th></th>
<th>Sí</th>
<th>No</th>
<th>No se sabe</th>
</tr>
</thead>
</table>

¿Se administró PPD? Sí __ No__

Si sí, Fecha en que fue administrada ___/____/____ Feche de lectura ___/____/____ Resultado de la prueba _____ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas)

Administrador de PPD ___________ ___________ firma nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD

Ciudad _____________________ Condado _______________________

Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí____ No___

Si sí, nombre del proveedor (médico o clinica, etc.) __________________________

EF12-11494A (Rev. 08/04)
C.30 How to Determine TB Risk

Risk of potential tuberculosis exposure as revealed by questionnaire

YES
Past TB skin test

NO
No skin test

YES
Skin test

NO

YES
Past TB skin test

NO

YES
Skin test

NO

(+): Positive

(-): Negative

(+): Positive

(-): Negative

NO further action

No skin test

No further action

Clinical exam*

Therapy completed

Clinical exam*

Clinical exam*

YES

NO

Clinical exam*

Clinical exam*

Clinical exam*

Clinical exam*

Clinical exam*

Clinical exam*

Clinical exam*

Symptoms of TB disease

YES

NO

Clinical exam*

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C.31 PPD Agreement for Texas Health Steps Providers

In order to receive State-supplied PPD at no cost to me, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization of which I am the physician in charge or equivalent, agree to the following:

1. I agree to provide/arrange training for all personnel in administering, reading, and recording the TB skin test results. I agree to instruct all patients that the TB skin test is a two (2)-part test and they must return in 48 to 72 hours for their test to be read by trained personnel so the test result can be documented. I agree to have all results documented in millimeters and a negative test will be recorded as 0 mm not negative. I agree to supply written documentation of the training to administer TB skin testing, reading and recording upon request of the health department issuing the PPD.

2. I agree to do the screening for TB risk factors on each patient and ONLY place the TB skin test on those patients that have a TB risk factor or have some other medical necessity that is documented in their chart or are entering foster care.

3. I agree to submit TB-400 forms or refer clients to the health department for medical evaluation or additional follow-up when they have latent TB infection (positive skin test result and a negative chest x-ray).

4. In accordance with the Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter A, I shall report to the local health authority any known or suspected case of TB within one working day and any new diagnosis of latent TB infection within one week.

5. I agree to submit the Monthly Tuberculin Skin Testing Form (EF12-12168). This form will be sent at the first of each month showing our TB testing numbers for the previous month. I agree to monitor my stock levels so that emergency orders will be kept to a minimum.

6. As a private clinic or health care facility, I agree to use this PPD only for TB screening of children as part of a Texas Health Steps medical check-up and to identify and document TB risk factors before placing the PPD.

7. Either the State or I may terminate this agreement at any time. My failure or the failure of any others outlined above to comply with these requirements will be grounds for the State to terminate this agreement.

Provider Signature

Date

A copy of this agreement will be returned to you.

Health Department Representative Signature

Date

EF12-12105 PPD Agreement (Rev. 6/05)
Appendix C

C.32 TVFC Patient Eligibility Screening Record

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: ______________________

Child’s Name:

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<th>Last Name</th>
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Child’s Date of Birth: ____________ mm/dd/yy

Parent/Guardian/Individual of Record:

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<th>Last Name</th>
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Provider’s/Clinic’s Name:

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</thead>
</table>

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one):

☐ (a) is enrolled in Medicaid, or
☐ (b) does not have health insurance, or
☐ (c) is an American Indian, or
☐ (d) is an Alaskan Native, or
☐ (e) is underinsured (has health insurance that Does Not pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
☐ (g) is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP)

☐ None of the above, not eligible for TVFC vaccine

Signature: ____________________________ Date: ______________________

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)
C.33 TVFC Patient Eligibility Screening Record (Spanish)

PROGRAMA EN TEXAS DE VACUNAS PARA NIÑOS (TVFC)
REGISTRO SOBRE LA ELEGIBILIDAD DEL PACIENTE

Propósito: Determinar la elegibilidad del paciente y procedencia de fondos para el reembolso del costo de las vacunas al Departamento de Servicios de Salud de Texas. Debe mantenerse un registro en la oficina del proveedor de atención de salud que refleje el estatus de todos los niños(as) y jóvenes de 18 años o menores, quienes reciben inmunizaciones a través del Programa Texas Vaccines for Children. El registro puede ser llenado por uno de los padres, por el tutor, por la persona que se está registrando o por el proveedor de atención de salud. Este mismo registro puede ser utilizado en todas las visitas siguientes, siempre y cuando el estatus de elegibilidad del niño(a) no haya cambiado. Aún cuando no es necesario verificar las respuestas, es necesario conservar este registro, o uno similar, para cada uno de los niños(as) a quienes se les aplican las vacunas.

Fecha de revisión de los antecedentes: ______________________

Nombre del niño(a): ________________________________________________________________

Apellido                                       Nombre                              Inicial del Segundo Nombre

Fecha de nacimiento del niño(a): ______________/_______/______

Padre / Tutor / Persona que se registra:

________________________________________________________________

Apellido                                        Nombre                              Inicial del Segundo Nombre

Nombre del proveedor de atención de salud:

________________________________________________________________

(Marque la primera categoría que corresponda, marque solamente una*). El(La) niño(a) mencionado(a) arriba tiene derecho a recibir las vacunas a través del Programa Texas Vaccines for Children (TVFC) debido a que él o ella:

☐ (a) está inscrito en Medicaid, o
☐ (b) no tiene seguro de salud, o
☐ (c) es indígena americano, o
☐ (d) es indígena de Alaska, o
☐ (e) tiene poca cobertura de seguro (tiene seguro que no paga por las vacunas, tiene un co-pago deducible que la familia no alcanza a pagar o tiene seguro que proporciona cobertura limitada para la prevención o el bienestar de la salud)*, o
☐ (f) es un paciente a quien se le provee servicio en una clínica de salud y quien no cumple con los criterios arriba descritos, o
☐ (g) es paciente quien recibe beneficios a través del Children’s Health Insurance Plan (CHIP).

Ninguno de los criterios arriba descritos, no es eligible para la vacuna bajo el programa TVFC.

*La vacuna neumocócica conjugada puede ser administrada en todas las clínicas inscritas en TVFC a niños(as) únicamente de las categorías “a”, “b”, “c”, “d”, “f”, “g” y “h”. Esta vacuna se le provee únicamente a niños(as) en la categoría “e” quienes tienen seguro de salud que no paga por las vacunas y que se presentan a recibir servicios en un centro federal de salud aprobado, clínica de salud para trabajadores migrantes o clínica rural de salud.

Firma: ___________________________ Fecha: ___________________________

Con pocas excepciones, usted tiene el derecho de pedir y ser informado(a) sobre información propia recaudada por el Estado de Texas. Usted tiene el derecho de recibir y revisar esta información al solicitarla. Usted también tiene el derecho de peticionar a la agencia estatal que lleve acabo correcciones a cualquier información que se determine incorrecta. Vea http://www.ths.state.tx.us para más información sobre Notificación de Privacidad. (Referencia: Codigo Guvernamental, Seccion 552.021, 552.023, 559.003 y 559.004).
Notificación de Privacidad: “Acúso recibo de una copia de Proveedor de atención de salud HIPAA Notificación de Privacidad”.

Texas Department of State Health Services
Immunization Branch

Stock No. C-10
Revised 02/05
C.34 TVFC Provider Enrollment (3 Pages)

**TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT**

- Initial enrollment*
- Re-enrollment
- Provider PIN Number

*Contact the Health Services Region (HSR) in your area to obtain PIN

---

**Name of Facility, Practice, or Clinic:**

**Provider Name (M.D., D.O., N.P., P.A., or C.N.M.*):**

**Contact:**

**Mailing Address:**

**Address for Vaccine Delivery:**

**Telephone Number:**

**E-mail Address:**

---

In order to participate in the Texas Vaccines for Children Program and/or to receive federally- and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1. This office/facility will screen patients for VFC eligibility at all immunization encounters, and administer VFC-purchased vaccine only to children 18 years of age or younger who meet one or more of the following criteria: (1) Is an American Indian or Alaska Native; (2) Is enrolled in Medicaid; (3) Has no health insurance; (4) Is underinsured: children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured), or has insurance with a co-pay or deductible the family cannot meet, (5) is a patient who receives benefits from the Children’s Health Insurance Plan (CHIP); (6) is a patient who is served by any type of public health clinic and does not meet any of the above criteria.

2. This office/facility will maintain all records related to the VFC program, including parent/guardian/authorized representative’s responses on the Patient Eligibility Screening Form for at least three years. If requested, this office/facility will make such records available to the Texas Department of State Health Services (DSHS), the local health department/authority, or the U.S. Department of Health and Human Services.

3. This office/facility will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, this office/facility deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.

4. This office/facility will provide Vaccine Information Statements (VIS) to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act which include reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Signatures are required for informed consent. (The Texas Addendum portion of the VIS may be used to document informed consent.)

5. This office/facility will not charge for vaccines supplied by DSHS and administered to a child who is eligible for the TVFC.

6. This office/facility may charge a vaccine administration fee to non-Medicaid VFC-eligible patients not to exceed $14.85. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services. For Medicaid patients, this office/facility agrees to accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

7. This office/facility will not deny administration of a TVFC vaccine to a child because of the inability of the child’s parent or guardian/individual of record to pay an administrative fee.

8. This office/facility will comply with the State’s requirements for ordering vaccine and other requirements as described by DSHS, and operate within the VFC program in a manner intended to avoid fraud and abuse.

9. This office/facility or the State may terminate this agreement at any time for failure to comply with these requirements. If the agreement is terminated for any reason this office/facility agrees to properly return any unused vaccine.

10. This office/facility will allow DSHS (or its contractors) to conduct on-site visits as required by VFC regulations.

---

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.
PROGRAMA EN TEXAS DE VACUNAS PARA NIÑOS (TVFC)
REGISTRO SOBRE LA ELEGIBILIDAD DEL PACIENTE

Propósito: Determinar la elegibilidad del paciente y procedencia de fondos para el reembolso del costo de las vacunas al Departamento de Servicios de Salud de Texas. Debe mantenerse un registro en la oficina del proveedor de atención de salud que refleje el estatus de todos los niños(as) y jóvenes de 18 años o menores, quienes reciben inmunizaciones a través del Programa Texas Vaccines for Children. El registro puede ser llenado por uno de los padres, por el tutor, por la persona que se está registrando o por el proveedor de atención de salud. Este mismo registro puede ser utilizado en todas las visitas siguientes, siempre y cuando el estatus de elegibilidad del niño(a) no haya cambiado. Aún cuando no es necesario verificar las respuestas, es necesario conservar este registro, o uno similar, para cada uno de los niños(as) a quienes se les aplican las vacunas.

Fecha de revisión de los antecedentes: ______________________
Nombre del niño(a): ________________________________________________________________
Fecha de nacimiento del niño(a): / /
Padre / Tutor / Persona que se registra:
________________________________________________________________
Nombre del proveedor de atención de salud:
________________________________________________________________

(Marque la primera categoría que corresponda, marque solamente una*). El(La) niño(a) mencionado(a) arriba tiene derecho a recibir las vacunas a través del Programa Texas Vaccines for Children (TVFC) debido a que él o ella:

☐ (a) está inscrito en Medicaid, o
☐ (b) no tiene seguro de salud, o
☐ (c) es indígena americano, o
☐ (d) es indígena de Alaska, o
☐ (e) tiene poca cobertura de seguro (tiene seguro que no paga por las vacunas, tiene un co-pago deducible que la familia no alcanza a pagar o tiene seguro que proporciona cobertura limitada para la prevención o el bienestar de la salud)*, o
☐ (f) es un paciente a quien se le provee servicio en una clínica de salud y quien no cumple con los criterios arriba descritos, o
☐ (g) es paciente quien recibe beneficios a través del Children’s Health Insurance Plan (CHIP).
☐ Ninguno de los criterios arriba descritos, no es eligible para la vacuna bajo el programa TVFC.

*La vacuna neumocócica conjugada puede ser administrada en todas las clínicas inscritas en TVFC a niños(as) únicamente de las categorías “a”, “b”, “c”, “d” y “e”. Esta vacuna se le provee únicamente a niños(as) en la categoría “e” quienes tienen seguro de salud que no paga por las vacunas y que se presentan a recibir servicios en un centro federal de salud aprobado, clínica de salud para trabajadores migrantes o clínica rural de salud.

Firma: _____________________________ Fecha: _____________________________

Con pocas excepciones, usted tiene el derecho de pedir y ser informado(a) sobre información propia recaudada por el Estado de Texas. Usted tiene el derecho de recibir y revisar esta información al solicitaria. Usted también tiene el derecho de pedir a la agencia estatal que leve acabo correcciones a cualquier información que se determine incorrecta. Véa http://www.tdh.state.tx.us para más información sobre Notificación de Privacidad. (Referencia: Código Guvernamental, Sección 552.021, 552.023, 559.003 y 559.004)

Notificación de Privacidad: “Acúso recibo de una copia de Proveedor de atención de salud HIPAA Notificación de Privacidad”.

Texas Department of State Health Services
Immunization Branch

Texas Department of State Health Services
Immunization Branch

Stock No. C-10
Revised 02/05
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<th>First Name</th>
<th>Middle Initial</th>
<th>Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)</th>
<th>National Provider Identification</th>
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Questions and Answers

Texas Vaccines For Children Program (TVFC)

Question 1: What is the TVFC?

Answer: This is our version of the Federal Vaccines For Children (VFC) Program. The TVFC was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed vaccines would be available at no cost to providers, in order to immunize children (birth - 18 years of age) who meet the eligibility requirements.

Why Enroll?

Question 2: Why should a health care provider enroll in the TVFC?

Answer:
- You can get free vaccine for your eligible patients.
- You will not need to refer patients to public clinics for vaccines.
- You can provide vaccinations to your patients as part of a comprehensive care package; this will enhance the opportunity for patients to find a medical home.

Patients Served

Question 3: Once enrolled, are providers required to immunize children who are not their patients?

Answer: No, you control whom you see in your practice.

Children Who Qualify

Question 4: Which children qualify for free vaccines?

Answer: All children (birth - 18 years of age) are eligible for free vaccine, except:
- Children with insurance that pays for immunization services, and
- Children whose parents or guardians are able to pay the co-pay or deductibles for immunization services.
Questions and Answers

Children’s Health Insurance Program (CHIP) Enrollment

**Question 5: Are children who are enrolled in CHIP eligible?**

**Answer:** Yes, through special arrangement CHIP children are also eligible.

Medicaid Enrollment

**Question 6: To participate in TVFC, must providers enroll as a Texas Medicaid Provider?**

**Answer:** No, however, if you are enrolled in the Texas Medicaid Program, you must enroll in TVFC in order to receive free vaccine.

**Question 7: Will the Texas Medicaid Program reimburse private providers for vaccines administered to Medicaid patients?**

**Answer:** The Texas Medicaid Program will not reimburse providers for the cost of the vaccine. However, the Texas Medicaid Program will reimburse providers for the administration of the vaccine.

Vaccine Related Fees

**Question 8: Why are there fee caps on what providers can charge for administering vaccine?**

**Answer:** Federal Legislation requires fee caps for administration on a statewide basis that balance the provider’s financial need and the patient’s ability to pay.

**Question 9: Will TVFC reimburse an administration fee for non-Medicaid, TVFC eligible children?**

**Answer:** No, for non-Medicaid TVFC eligible children, providers may charge a maximum of $14.85 per vaccine directly to the patient; administration fees may not exceed this amount. (Combination vaccines such as DTaP are considered one vaccine.)
Questions and Answers

Question 10: Will providers be required to increase the amount of vaccine information materials they provide to parents because of the TVFC?

Answer: No, materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.

Eligibility Status

Question 11: Must providers screen patients for eligibility status each time they come for a vaccination visit?

Answer: Yes, providers must screen patients for eligibility status each time they come for a vaccination visit. However, a new eligibility form does not need to be completed unless the patient’s eligibility status has changed.

Question 12: How are providers expected to verify responses for TVFC eligibility?

Answer: Providers are not expected to do anything more than ask the patient what the child’s eligibility status is and then record the response. TVFC provides a Patient Eligibility Screening Form that can be used for this.

Question 13: Why must providers complete a Provider Profile describing patients by eligibility category?

Answer: This information allows the Texas Department of State Health Services to determine how the cost of vaccine will be divided among state and federal funds. Each year, you may find your profile information has changed. The Provider Profile must be updated annually, in accordance with Federal requirements.