APPENDIX A: THE STEPS FORMS

A.1 Claim Forms

A.2 Child Health Clinical Records

A.3 Guidelines for Tuberculosis Skin Testing

A.4 Laboratory Forms

CH.37 Child Health History (2 Pages)

CH.38 Child Health Record (Birth–1 Month) (2 Pages)

CH.39 Child Health Record (2–6 Months) (2 Pages)

CH.40 Child Health Record (7–12 Months) (2 Pages)

CH.41 Child Health Record (13 Months–2 Years) (2 Pages)

CH.42 Child Health Record (3–5 Years) (2 Pages)

CH.43 Child Health Record (6–10 Years) (2 Pages)

CH.44 Hearing Checklist for Parents

CH.45 Hearing Checklist for Parents (Spanish)

CH.46 Mental Health Interview Tool/Referral Form (Ages 0–2 Years)

CH.47 Mental Health Interview Tool/Referral Form (Ages 3–9 Years)

CH.48 Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

CH.49 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

CH.50 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)

CH.51 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish)

CH.52 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

CH.53 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

CH.54 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages)

CH.55 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages) (Spanish)

CH.56 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages) (Spanish)

CH.57 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages) (Spanish)

CH.58 Risk Assessment for Lead Exposure: Parent Questionnaire, Form Pb-110 (2 Pages)

A.5 Tuberculosis Screening and Education Tool

CH.59 TB Questionnaire

CH.60 Cuestionario Para la Detección de Tuberculosis

CH.61 How to Determine TB Risk

CH.62 PPD Agreement for Texas Health Steps Providers

CH.63 TVFC Patient Eligibility Screening Record

CH.64 TVFC Patient Eligibility Screening Record (Spanish)

CH.65 TVFC Provider Enrollment (3 Pages)

CH.66 TVFC Questions and Answers (3 Pages)
A.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 Section 6: Claims Filing (Vol. 1, General Information).


A.2 Child Health Clinical Records

The use of forms ECH 1–7 is optional. These forms were developed to help providers document all components of the medical checkup. THSteps requires the following forms: Hearing Checklist for Parents, Tuberculosis (TB) Questionnaire, Risk Assessment for Lead Exposure, and the DSHS State Laboratory forms. All of these forms can be downloaded from the THSteps website at http://dshs.state.tx.us/thsteps/forms.shtm. Lead poisoning screening questionnaires can be downloaded from the Texas Childhood Lead Poisoning Prevention Program (TX CLPPP) website at www.dshs.state.tx.us/lead/providers.shtm.

Forms CH-9W through CH-12W may be downloaded from the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/growthcharts/clinical_charts.htm.

<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>
</tr>
<tr>
<td>CH-10W</td>
<td>Growth Chart - Infant Boy</td>
</tr>
<tr>
<td>CH-11W</td>
<td>Growth Chart - Child Girl</td>
</tr>
<tr>
<td>CH-12W</td>
<td>Growth Chart - Child Boy</td>
</tr>
<tr>
<td>ECH-1</td>
<td>Child Health History</td>
</tr>
<tr>
<td>ECH-2</td>
<td>Preventive Health Visit - Birth to 1 Month</td>
</tr>
<tr>
<td>ECH-3</td>
<td>Preventive Health Visit - 2–6 Months</td>
</tr>
<tr>
<td>ECH-4</td>
<td>Preventive Health Visit - 7–12 Months</td>
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<tr>
<td>ECH-5</td>
<td>Preventive Health Visit - 13 Months to 2 Years</td>
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<tr>
<td>ECH-6</td>
<td>Preventive Health Visit - 3–5 Years</td>
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<td>ECH-7</td>
<td>Preventive Health Visit - 6–10 Years</td>
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<td></td>
<td>Form Pb-110, Risk Assessment for Lead Exposure</td>
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<td></td>
<td>TB Questionnaire</td>
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For forms for documenting medical checkups for adolescents, 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.
A.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/. 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.

A.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.shtm.
# 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**

**Flu-like illness or high temp.**

**Kidney or bladder infection**

**STDs**

**Hepatitis (A, B, or C)**

**Exposure to TB**

**Exposure to lead/chemicals**

**Dental disease**

### 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
- **PGM** - Paternal Grandmother
- **MGF** - Paternal Grandfather
- **MA** - Maternal Aunt
- **MU** - Maternal Uncle
- **PG** - Paternal Grandparent
- **PA** - Paternal Aunt
- **PU** - Paternal Uncle
- **MGM** - Maternal Grandmother
- **MGF** - Maternal Grandfather
- **MA** - Maternal Aunt
- **MU** - Maternal Uncle

- **Anemia/blood disorder**
- **Heart disease before age 50**
- **High blood pressure**
- **Cholesterol req. treatment**
- **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**

**Other immunosuppression**

**Dental decay**

**Alcohol/drug abuse**

**Tobacco use**

**Learning disorder**

**Mental retardation**

**Psychiatric disorder**

**Physical/sexual/emotional abuse**

**Domestic violence**

**Other**

**Explanation of positive history:**

### Client Information

**Name:**

**DOB:** / / __________ **Age:** __________ **Sex:** ______

**SSN/Record No.:**

**Race/Ethnicity:**

**Informant/Relationship:**

**Medical Home:**

**Place of birth:**

**Hours of labor:**

**Comprehension:**

**Preterm:**

**Premature (Weeks):**

**Breech:**

**More than 2 weeks overdue:**

**Multiple birth:**

**Other:**

### Nursery Course

**Birth Weight:** _______ **Birth Length:** _______ **FOC:** _______

**Difficulty with initial breathing:**

**Heart murmur:**

**Jaundice req. treatment:**

**Infection:**

**Seizures:**

**Transfusion:**

**Explaination:**

**Birth attendant:**

**Explanation:**

**Age at discharge:** _______ **ICN:** _______ **days**

**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:**

**Hospizations:**

**Surgery:**

**Medications:**

**Anemia:**

**Early childhood caries:**

**Hepatitis:**

**Strep throat:**

**Ear infections:**

**Bladder/kidney infections:**

**Pneumonia:**

**Substance use (alcohol, drug, tobacco):**

**Vision problems:**

**Hearing problems:**

**Seizures:**

**Environmental toxin exposure (lead, etc.)**

**Allergies:**

**Asthma:**

**Eczema:**

**Substance use (alcohol, drug, tobacco):**

**Other:**

**Developmental delays:**

**Explanation:**

**Date:** __________ **Signature/Title:**

**Signature/Title:**

**Date:** __________ **Signature/Title:**

**Signature/Title:**
Child Health History

If used for documentation: ________________________________

Patient’s Name: ________________________________

Date: ________________________________

Progress Notes

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**Child Health Record (Birth–1 Month)**

**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: ____________________________

### 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: ____________________________
- Medications taken regularly — Type/Reason: ____________________________

### Physical Examination
- Temp ______
- Pulse ______
- Resp ______
- FOC ______
- Height ______
- Weight ______
- (%) ______
- (%) ______

### Additional documentation:
- Appearance ______
- Head/face ______
- Skin ______
- Eyes ______
- Ears ______
- Nose ______
- Mouth/throat ______
- Teeth ______
- Neck ______
- Chest/breasts ______

### Neurologic:
- Heart/pulses ______
- Lungs ______
- Abdomen ______
- Genitalia/anus ______
- Spine/hips ______
- Extremities ______
- Muscle tone ______
- DTRs ______
- Primitive reflexes ______

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

### Sensory
- Vision Screen: ______ Normal ______ Abnormal
- Hearing Screen: ______ Normal ______ Abnormal
- Screen used: ______
- Hearing Checklist for Parents

### Health Education
- Assessment:
  - 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 __________

### Plan
- Next appointment: ____________________________
Birth–1 Month
If used for documentation: ____________________________________________
Patient’s Name: ____________________________________________________
Date: _____________________________________________________________

Key Elements

**Systems Review**
Skin: Rashes, infections, jaundice, cyanosis
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, 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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Child Health Record (2–6 Months) (2–6 Months)

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: __________________________
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/Interim History

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 __________ Length ___________ Weight ____________
(%) _________ (%) _________ (%) _________

NA NE NA NE
Appearance — Heart/pulses
Head/fontanels — Lungs
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:

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:
Y N
Length of feedings: __________________________
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
_____ No solids until 4 months
_____ Formula preparation
_____ Infant held (no bottle in bed)

Assessment

Date: ________________ Signature/Title: __________________________________

Health Promotion

_____ Immunizations
_____ Thermometer use, Tylenol
_____ Teething, wipe teeth
_____ When to call doctor
_____ Well-child care
_____ Family planning

Plan

Dental Referral
WIC: _____ Referred _____ Refused _____ N/A
Immunizations:
_____ Up to date
_____ To be given today
_____ Deferred
Explain:
Lab: Hct/Hgb _________ Lead questionnaire (at 6 months) _________
Newborn Screening: Up to date _________ To be done today
Next appointment:

Date: ________________ Signature/Title: __________________________________
2–6 Months

If used for documentation: ____________________________________

Patient's Name: ____________________________________________

Date: _____________________________________________________

Key Elements

Systems Review

Skin: Rashes, infections

Eyes: Eye discharge, deviation, excessive tearing

Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing

Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting

(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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CH.40 Child Health Record (7–12 Months) (2 Pages)

7–12 Months

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:  
  - Y
  - N
- Mental Health  
  (see "Key Elements" on reverse side):

Child’s Health/Interim History

- Allergies:  
  - Y
  - N
- 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
- Length
- Weight
- (%) (%) (%)

- N
- A
- NE

- Appearance
- Head/Fontanel
- Skin/nodes
- Eyes
- Ears
- Nose
- Mouth/throat
- Teeth
- Neck
- Chest/Abdomen

- Lungs
- Abdomen
- Genitalia/anus
- Spine/hips
- Extremities

- Neurologic:
- Muscle tone
- DTRs

Additional documentation:

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 (stairs, gates)
  - Choking management
  - Water safety/temperature
  - Poisoning
  - Child proofing
  - Passive smoking

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

Assessment

- TB Risk Screening Tool (12 months):
- Dental referral made:  
  - Y
  - N
- 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
- Hct/Hgb
- Blood lead test (at 12 months)
- Lead questionnaire (at 9 months)

Next appointment:

Date: __________________________ Signature/Title: __________________________

CH.304

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7–12 Months
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, 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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CH.41 Child Health Record (13 Months–2 Years) (2 Pages)

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:

Client Information

Name: ____________________________
DOB: __________ / __________ / __________
Age: __________ Sex: __________
SSN/Record No.: __________
Race/Ethnicity: __________
Informant/Relationship: __________
Medical Home: __________

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: _______ Hearing Checklist for Parents

Health Education

Injury Prevention:
Car safety restraints ___ Sibling rivalry ___
Choking, unsafe toys ___ Toilet training ___
Poisoning ___ Health Promotion ___
Burns ___ Immunizations ___
Water safety/temp ___ Smoking in home ___
Supervised play ___ Well-child care ___
Electrical injury ___ Dental care, appointment ___
Passive smoking ___ Family planning ___

Behavior:
Parent/infant interaction ___ Daycare ___
Social interaction ___ ___
Limit TV ___ ___
Set limits ___ ___

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

Injury Prevention:
___ Car safety restraints
___ Choking, unsafe toys
___ Poisoning
___ Burns
___ Water safety/temp
___ Supervised play
___ Electrical injury
___ Passive smoking

Behavior:
___ Parent/infant interaction
___ Social interaction
___ Limit TV
___ Set limits

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

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/Interim History

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

BMI (2 years) ______

Temp _______ Pulse _______ Resp _______
FOC _______ Length _______ Weight _______
(%) _______ (cm) _______ (kg) _______

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:

Assessment

Plan

TB Risk Questionnaire (2 years) _______

Dental referral made: _______ Y _____ N
WIC: _______ Referred _______ Refused _______ N/A
Immunizations: _______ Up to date _______ To be given today _______ Deferred _______
Explain:
Lab: _______ Hct/Hgb _______ Blood lead test (at 2 years) _______
Lead questionnaire: (at 15 months) _______ and (at 18 months) _______

Next appointment:

Date: _______ Signature/Title: __________ Signature/Title: __________
### Systems Review

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

### Mental Health

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

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

### Progress Notes

________________________________________________________________________________________
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________________________________________________________________________________________
**3–5 Years**

Department of State Health Services  
Child Health Record  
Preventive Health Visit

### Family Profile and Health

- No change in household since last visit
- Total adults living in home:
- Total children living in home:
- Primary caretaker for this child:
- Medical Home:

### 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/Interim History

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

- BMI:
- Temp
- Pulse
- Resp
- BP
- Height
- Weight
- ( % )
- ( % )

- Appearance
- Heart/pulses
- Lungs
- Abdomen
- Genitalia/anus
- Spine
- Extremities
- Muscle tone
- DTRs

### Nutrition

- Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental* Y N
- If answered yes, further assessment needed.

### Sensory

- Vision Screen: Normal Abnormal
- Hearing Screen: Normal Abnormal

### Health Education

- Injury Prevention
  - Car safety restraints
  - Poisoning
  - Fire safety
  - Firearms
  - Street, water, bicycle safety
  - Scissors/sharp objects
  - Stranger safety
  - Teaching telephone no. & address
  - Self-safety
  - Passive smoking
- Behavior
  - Talk/read with child
  - Exploration
  - Limit television
  - Discipline, consistency
- Health Promotion
  - Family planning
  - Daycare
  - Nutrition
- Physical activity

### Assessment

- Plan

- TB Risk Screening Tool:
- Dental referral made:
- WIC: Referred Refused N/A
- Immunizations: Up to date To be given today Deferred
- Lab: Lead questionnaire: Y N
- Hct/Hgb

Next appointment:

Date: Signature/Title: Signature/Title:
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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6–10 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:

Mental Health

(+) indicates need for further assessment

- Sleep Problems
- Behavior/problems
- Relationship problems with parents, siblings, peers
- Problems in school

Grade Level

Comments:

Child’s Health/Interim History

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/sealants:

BMI

Physical Examination

Temp
BP

Pulse
Resp

Height
Weight

(%) (%)

NA NE

NA NE

N A NE

N A NE

N A NE

- Appearance
- Head/fontanels
- Skin/nodes
- Eyes
- Ears
- Nose
- Mouth/throat
- Teeth
- Neck
- Chest/breasts
- (Tanner stage)

- Heart/pulses
- Lungs
- Abdomen
- Genitalia/anus
- (Tanner stage)
- Spine
- Extremities
- Neurologic:
- Muscle tone
- DTRs

Additional documentation:

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

Mental Health

(+ indicates need for further assessment)

- Sleep Problems
- Behavior/problems
- Relationship problems with parents, siblings, peers
- Problems in school

Grade Level

Comments:

Client Information

Name:
DOB: / / Age: Sex:
SSN/Record No.:
Race/Ethnicity:
Informant/Relationship:
Medical Home:

Sensory

Vision Screen:

Hearing Screen:

Health Education

Injury Prevention

- Seat belt/auto safety
- Bicycles/ATV
- Athletics
- Water safety
- Smoke detectors
- Firewall safety

Behavior

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

Communication/conflict resolution

Health Promotion

- Limit TV viewing
- Passive smoking
- Regular exercise
- Pubertal changes/sexuality

Dental care/sealants

Nutrition

- Healthy diet/snacks
- Junk food
- Iron-rich foods

Assessment

Plan

TB Risk Screening Tool:

Dental referral made:

Immunizations:

- Up to date
- To be given today
- Deferred

Explain:

Lab:

Hct/Hgb

Next appointment:

Date: ____________________ Signature/Title: __________________________________

Signature/Title
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

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

Progress Notes

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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></th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 3 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your baby get quiet for a moment when you talk to him/her?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your baby act startled or stop moving for a moment when there are sudden loud noises?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 to 6 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
<td></td>
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<tr>
<td>❑❑</td>
<td>Does your baby smile or stop crying when you or someone else he/she knows speaks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 to 9 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your baby stop and pay attention when you say “no” or call his/her name?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your baby move his/her head around to try and find out where a new sound is coming from?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your baby make strings of sounds (“ba ba ba, da da da”)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 to 15 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
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</tr>
<tr>
<td>❑❑</td>
<td>Does your baby point to familiar objects if you ask (“dog,” “light”)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 to 24 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<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>
<td></td>
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<tr>
<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>
<td></td>
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</tr>
<tr>
<td>25 to 36 months</td>
<td>❑❑</td>
<td>❑❑</td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your child answer different kinds of questions (“When...,” “Who...,” “What...,”)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>❑❑</td>
<td>Does your child notice different sounds (telephone ringing, shouting, doorbell)?</td>
<td></td>
<td></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.

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Age</th>
<th>Result</th>
<th>Signature of Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
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</tbody>
</table>

Department of State Health Services
Publication No. EFO5-12234
8/05
**CH.45 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>De 0 a 3 meses</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><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 ‘no’ o lo llama por su nombre?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>¿Su bebé dirige la mirada o gira la cabeza hacia todos lados y trata de encontrar de dónde viene algún sonido nuevo?</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 ('el perro', 'la luz')?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td><strong>De 16 a 24 meses</strong></td>
<td></td>
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<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 ('Vé por tus zapatos')?</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td><strong>De 25 a 36 meses</strong></td>
<td></td>
<td></td>
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<tr>
<td>¿Su hijo responde a diferentes tipos de preguntas ('Cuándo', 'Quién', 'Qué')?</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**

<table>
<thead>
<tr>
<th>Fecha de la visita</th>
<th>Edad</th>
<th>Resultado</th>
<th>Firma del proveedor</th>
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</table>
Mental Health Interview Tool/Referral Form (Ages 0–2 Years)

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 1 to 2 Years
  - Anxious
  - Cries excessively
  - Cries too little
  - Irritable
  - Angry
  - Sad
  - Cries excessively
  - Fearful
  - Cries too little

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

- Infants 1 to 2 Years
  - Overactive
  - Listlessness
  - Harms others
  - Frequent temper tantrums

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

- Infants 1 to 2 Years
  - No eye contact or smile
  - Stiffens and arches
  - Not responsive
  - Language delay

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

- Infants (> 8 months) 1 to 2 Years
  - No communication skills (pointing to request an object) or efforts to make words
  - 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:**
CH.47  Mental Health Interview Tool/Referral Form (Ages 3–9 Years)

Mental Health Interview Tool/Referral Form (Ages 3–9 Years)

Mental Health Interview Tool/Referral Form

Child’s Name: ______________________________

Birth Date: _________________________________

Ages 3 to 9 Date: _______________________________________

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
- Sulen
- 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?

- 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: _____________________________________________________________________________
Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

Child's Name: _______________________

Birth Date: _________________________

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 aguers easily
☐ Sullen
☐ Fearful or anxious
☐ Bored

Behavior:
Does your child (do you) behave in ways that seems 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: ____________________________________________________________
CH.49 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

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 seems out of the ordinary for your (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: ____________________________________________
**Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)**

**Mental Health Parent Questionnaire**

<table>
<thead>
<tr>
<th>Ages Birth to 2 Years</th>
<th>Child’s Name: _____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Today’s Date:</td>
<td>_______________________</td>
</tr>
</tbody>
</table>

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

|                  |              |
| **Behavior**     |              |
| Infants          |              |
| ❑ Is overactive  | ❑ Is overactive|
| ❑ Is listless (has little energy) | ❑ Harms others |
| ❑ Is listless (has little energy) | ❑ Has temper tantrums often |

|                  |              |
| **Social Interaction** |          |
| Infants           |              |
| ❑ Does not make eye contact or smile | ❑ Does not make eye contact or smile |
| ❑ Stiffens and arches back | ❑ Does not respond to you |
| ❑ Does not respond to you | ❑ Does not say any words yet |
|                  | ❑ Clings to you too much |

|                  |              |
| **Thinking**     |              |
| Infants          |              |
| ❑ (>8 months) Does not point to or ask for things or try to make words | ❑ Does not trust others |
|                  | ❑ Has problems concentrating or paying attention |

Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No

Does your child do things that concern you or seem strange for their age? ❑ Yes ❑ No

Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No

Do you think your child is as bright and thinks as clearly as others their age? ❑ Yes ❑ No
<table>
<thead>
<tr>
<th>Physicals</th>
<th>Do you have any concerns about these things?</th>
<th>❑ Yes  ❑ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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  ❑ No</td>
</tr>
<tr>
<td>Infants to 2 Years</td>
<td>❑ Is low weight or has a lot of weight</td>
<td>❑ Has sleeping problems (wakes a lot at night)</td>
</tr>
<tr>
<td></td>
<td>❑ Vomits (throws up) often</td>
<td>❑ Has little energy</td>
</tr>
<tr>
<td></td>
<td>❑ Has eating problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(poor appetite, eats non-foods)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Is anything causing your family stress right now?</th>
<th>❑ Yes  ❑ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? When? ❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment initiated? ❑ Yes ❑ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did the mother of this child use drugs or alcohol during the pregnancy? ❑ Yes ❑ No</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: _______________________________________________________________
## 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 si usted está preocupado, favor de informarnos.

<table>
<thead>
<tr>
<th>SENSAMIENTOS</th>
<th>¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bebés</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siente miedo</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Llora mucho</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Llora muy poco</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>De 1 a 2 Años</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es de mal carácter</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es enojón</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es triste</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es malhumorado</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>PENSAMIENTOS</th>
<th>¿Piensa usted que su niño es tan inteligente y que piensa tan claramente como otros niños de su edad?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bebés</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(&gt;8 meses) No pide ni señala a las cosas o trata de decir palabras</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>De 1 a 2 Años</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No le tiene confianza a otros</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene problemas para concentrarse y poner atención</td>
<td>❑</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fecha: _______________ Firma: __________________________________________________________________

Parentesco con el paciente: __________________________________________________________

---

### Problemas Físicos

<table>
<thead>
<tr>
<th>Problema</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Se preocupa usted sobre los siguientes problemas físicos?</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></td>
<td></td>
</tr>
</tbody>
</table>

---

### De recién nacidos a 2 Años

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

---

### Otros

<table>
<thead>
<tr>
<th>Problema</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Hay algo que le esté causando tensión a su familia ahora?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma? ¿Cuándo? ¿Empezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma? ¿Cuándo? ¿Empezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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

---

Fecha: ___________ Firma: __________________________
# Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

**Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)**

**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.

**Mental Health Parent Questionnaire**

**Child’s Name:** __________________________

**Birth Date:** ___________________________

**Today’s Date:** __________________________

**Ages 3 to 9 Years**

**F e e l i n g s**

Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No

- ❑ Is restless
- ❑ Is sad or cries easily
- ❑ Is overly guilty
- ❑ Lacks remorse

- ❑ Is irritable, angers or temper tantrums easily
- ❑ Is sullen
- ❑ Fearful

**B e h a v i o r**

Does your child do things that seem strange for their age? ❑ Yes ❑ No

- ❑ Has problems in school
- ❑ Harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ 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

**S o c i a l i n t e r a c t i o n**

Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No

With other family members or adults? ❑ Yes ❑ No

With playmates? ❑ Yes ❑ No

- ❑ Withdrawing 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

**T h i n k i n g**

Are any of these a problem for your child? ❑ Yes ❑ No

- ❑ 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
<table>
<thead>
<tr>
<th>Physical Problems</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns about these things?</td>
<td>Is this child accident-prone?</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</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>Is anything causing your family stress right now?</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>❑ Has daytime wetting</td>
<td>Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from?</td>
</tr>
<tr>
<td>❑ Soils pants</td>
<td>_______________ When? ________</td>
</tr>
<tr>
<td>❑ Will not eat</td>
<td>❑ Yes ❑ No</td>
</tr>
<tr>
<td>❑ Has headaches</td>
<td>Treatment initiated?</td>
</tr>
<tr>
<td>❑ Has lost or gained a lot of weight</td>
<td>❑ Yes ❑ No</td>
</tr>
<tr>
<td>Yes</td>
<td>Is this child at risk for out-of-home placement because of behavior problems?</td>
</tr>
<tr>
<td>No</td>
<td>❑ Yes ❑ No</td>
</tr>
</tbody>
</table>

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

Date: ____________  Signature: ______________________________________________________

Relation to patient: _______________________________________________________________
## Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

### Cuestionario de la Salud Mental para los Padres

<table>
<thead>
<tr>
<th>Nombre del Niño:</th>
<th>Fecha de Nacimiento:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Fecha:** _______________________

Para los Padres: Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica 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.

### SENTIMIENTOS

<table>
<thead>
<tr>
<th>¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

- Es inquieto
- Es triste o llora fácilmente
- Se siente muy culpable
- No tiene remordimiento

### COMPORTAMIENTO

<table>
<thead>
<tr>
<th>¿Hace su niño cosas que le parezcan extrañas para su edad?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

- Tiene problemas en la escuela
- Lastima a otros niños o a los animales
- No le interesan las cosas que antes le gustaban
- Juega juegos sexuales con otros niños, juguetes, o animales
- Destroza cosas personales u ajenas
- Roba

### INTERACCIONES SOCIALES

<table>
<thead>
<tr>
<th>¿Se preocupa sobre cómo se lleva su niño con usted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

- Se aleja y no ve a nadie a los ojos
- La mayoría del tiempo no se le despega
- Se le dificulta hacer y mantener amistades
- Es desafiante, tiene un problema de disciplina
- Hace berrinches temperamentos fuertes o frecuentemente

### PENSAMIENTOS

<table>
<thead>
<tr>
<th>¿Son algunas de estas características un problema para su niño?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

- Se confunde frecuentemente (no entiende lo que está pasando)
- Sueña mucho despierto
- Se distrae, no pone atención
- Tiene pensamientos muy extraños
- Se está atrasando en el trabajo de la escuela (sus grados están bajando)
### Problemas Físicos

<table>
<thead>
<tr>
<th>Problema</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Se orina durante el día</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensucia sus pantalones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No quiere comer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene dolores de cabeza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ha perdido o aumentado mucho de peso</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se vomita frecuentemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene dolores de estómago frecuentemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No tiene energía</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 este niño a tener accidentes?</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 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>Si sí, ¿en qué forma?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregunta</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Cuándo? ¿Empezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Corre el riesgo este niño de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?</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: ________________________________________________
Mental Health Parent Questionnaire (Ages 10–12 Years)

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 guilty
- [ ] Is irritable or angers easily

- [ ] Is sullen
- [ ] Is fearful
- [ ] Is bored

**Behavior**

- [ ] Has problems in school
- [ ] Threatens or harms other children or animals
- [ ] Lacks interest in things s/he used to enjoy
- [ ] Is involved in sexual activity
- [ ] Destroys possessions or other property
- [ ] Steals

- [ ] Refuses to talk
- [ ] Sets fires
- [ ] Is overactive
- [ ] Hurts himself or herself
- [ ] Has been in trouble with the police

**Social Interaction**

- [ ] Prefers to be alone
- [ ] Has a hard time making and keeping friends
- [ ] Is defiant, a disciplinary problem

- [ ] Picks on others a lot or often gets into fights (hitting, etc.)
- [ ] Argues too much
- [ ] Will not go to school

**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 or suicide a lot
- [ ] Often cannot remember things
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

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

Is this child (are you) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Does your child (do you) drink or 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: ___________________________________________
Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages) (Spanish)

Cuestionario 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>¿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>Es inquieto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es triste o llora fácilmente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se siente culpable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es de mal carácter o se enoja fácilmente</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Hace su niño cosas que le parezcan extrañas para su edad?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiene problemas en la escuela</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amenaza o lastima a otros niños o a los animales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No le interesan las cosas que antes le gustaban</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participa en actividades sexuales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destructuye cosas personales o ajenas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roba</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Se preocupa sobre cómo se lleva su niño con usted?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Se niega a hablar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provoca incendios</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Es demasiado activo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se lastima</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ha tenido problemas con la policía</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>¿Son algunas de estas características un problema para su niño?</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Se confunde frecuentemente (no entiende lo que está pasando)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sueña mucho despierto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se distrae, no pone atención</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiene pensamientos muy extraños</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Se está atrasando en el trabajo de la escuela (sus grados están bajando)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
¿Se preocupa usted sobre los siguientes problemas físicos?  □ Sí  □ No
Si piensa que su niño tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera debido a ese problema?

<table>
<thead>
<tr>
<th>Problemas</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>La falta energía</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>USA laxantes</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Se vomita frecuentemente</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>No come delante de la gente, come después a escondidas</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Tiene dolores de cabeza</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Ha perdido o aumentado mucho peso</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Tiene problemas para dormir, pesadillas, sonambulismo, despierta temprano, despierta seguido por la noche</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

¿Es propenso a tener accidentes su niño?  □ Sí  □ No

<table>
<thead>
<tr>
<th>Otros</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 al abuso físico, sexual o emocional?</td>
<td>□ Sí □ No</td>
<td></td>
</tr>
<tr>
<td>Si sí, ¿en qué forma?</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>¿Cuándo?</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>¿Empezó el tratamiento?</td>
<td>□ Sí □ No</td>
<td></td>
</tr>
<tr>
<td>¿Corre este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?</td>
<td>□ Sí □ No</td>
<td></td>
</tr>
<tr>
<td>¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancia como las drogas y bebidas alcohólicas?</td>
<td>□ Sí □ No</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: __________________________________________
# Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages)

**Mental Health Parent Questionnaire**

**Teen’s Name:** ____________________

**Birth Date:** ____________________

**Ages 13 to 20 Years**

**Today’s Date:** ____________________

**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.

### Feelings

- Restless
- Sad or cry easily
- Guilty
- Irritable or angered easily
- Sullen
- Fearful
- Bored

### Behavior

- Have problems in school or work
- Threaten or harm other children or animals
- Lack interest in things you used to enjoy
- Is involved in sexual activity
- Destroy possessions or other property
- Refuse to talk
- Set fires
- Over-active
- Hurt yourself
- Have been in trouble with the police
- Steal
- Refuse to talk
- Set fires
- Over-active
- Hurt yourself
- Have been in trouble with the police

### Social Interaction

- Prefer to be alone
- Have a hard time making and keeping friends
- Defiant, a disciplinary problem
- Pick on others a lot or often get into fights (hitting, etc.)
- Argue too much
- Will not go to school

### Thinking

- Frequently confused (does not understand what is going on)
- Daydream a lot
- Distracted, do not pay attention
- Have very strange thoughts
- Schoolwork is slipping (grades going down)
- Do not trust others
- See or hear things that are not there
- Blame others for your misdeeds or thoughts
- Talk about death or suicide a lot
- Often cannot remember things
<table>
<thead>
<tr>
<th>Physical problems</th>
<th>Treatment initiated?</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any concerns about these things?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If you think you (your teen) may have a health problem, have you (has he/she) seen a doctor or nurse about the problem?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>❑ Lack energy</td>
<td>❑ Have headaches</td>
<td></td>
</tr>
<tr>
<td>❑ Use laxatives</td>
<td>❑ Have lost or gained a lot of weight</td>
<td></td>
</tr>
<tr>
<td>❑ Vomit (throw up) often</td>
<td>❑ Have sleeping problems, nightmares, sleep-walking, early waking, frequent night waking</td>
<td></td>
</tr>
<tr>
<td>❑ Won’t eat in front of people, sneak food later</td>
<td>❑ Have stomachaches often</td>
<td></td>
</tr>
</tbody>
</table>

- Are you (is your teen) accident-prone? Yes No
- Is anything causing your family stress right now? Yes No
- Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? _______________. When? ________ Yes No
- Treatment initiated? Yes No
- Are you (is this teen) at risk for out-of-home placement because of behavior problems? Yes No
- Do you (does your child) drink or use drugs (including street or over-the-counter)? Yes No
- Have you (has this teen) 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: ________________________________________________________________
Cuestionario de la Salud Mental
para los Padres
De 13 a 20 Años de Edad

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>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad?</td>
<td></td>
</tr>
<tr>
<td>Es inquieto</td>
<td>Es malhumorado</td>
</tr>
<tr>
<td>Es triste o llora fácilmente</td>
<td>Siente miedo</td>
</tr>
<tr>
<td>Se siente culpable</td>
<td>Se aburre</td>
</tr>
<tr>
<td>Es irrita o enoja fácilmente</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Le preocupa cómo se lleva su hijo con los miembros de la familia?</td>
<td></td>
</tr>
<tr>
<td>¿Con otros adultos?</td>
<td></td>
</tr>
<tr>
<td>Prefiere estar solo</td>
<td>Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)</td>
</tr>
<tr>
<td>Se le dificulta hacer y mantener amistades</td>
<td>Discute mucho</td>
</tr>
<tr>
<td>Es desafiante, tiene un problema de disciplina</td>
<td>No quiere asistir a la escuela</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Son algunas de estas características un problema para su hijo?</td>
<td></td>
</tr>
<tr>
<td>Se confunde frecuentemente (no entiende lo que está pasando)</td>
<td>No le tiene confianza a los demás</td>
</tr>
<tr>
<td>Sueña mucho despertado</td>
<td>Mira u oye cosas que no están allí</td>
</tr>
<tr>
<td>Se distrae, no pone atención</td>
<td>Culpas a otros por algo que hizo mal o por sus pensamientos</td>
</tr>
<tr>
<td>Tiene pensamientos muy extraños</td>
<td>Habla mucho sobre la muerte o el suicidio</td>
</tr>
<tr>
<td>Se está atrasando en el trabajo de la escuela (sus grados están bajando)</td>
<td>Frecuentemente no se acuerda de cosas</td>
</tr>
<tr>
<td>PROBLEMAS FÍSICOS</td>
<td>SÍ</td>
</tr>
<tr>
<td>-------------------</td>
<td>----</td>
</tr>
<tr>
<td>No tiene energía</td>
<td></td>
</tr>
<tr>
<td>Usa laxantes</td>
<td></td>
</tr>
<tr>
<td>Se vomita frecuentemente</td>
<td></td>
</tr>
<tr>
<td>No come delante de la gente, come después a escondidas</td>
<td></td>
</tr>
<tr>
<td>Tiene dolores de estómago frecuentemente</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEMAS OTROS</th>
<th>SÍ</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Es su hijo propenso a tener accidentes?</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 su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sí sí, ¿en qué forma?</td>
<td></td>
<td>¿Cuándo?</td>
</tr>
<tr>
<td>¿Empezó el tratamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o 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: ________________________________________________________
The risk assessment questionnaire contains 6 questions that appear on page 2, and is designed to be administered to the parent by the healthcare provider. Questions are in English and Spanish to assist with Spanish speaking parents.

**Instructions:**
- This questionnaire may be used with any child, whether or not enrolled in Texas Health Steps.
- Medicaid requires a blood lead test for all Texas Health Steps patients at 12 months and 24 months. For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.
- At any visit, you may choose to perform a blood lead test rather than use the risk assessment questionnaire.
- 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.

### Schedule for Blood Lead Testing and Use of Risk Assessment Questionnaire

<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></td>
</tr>
<tr>
<td>9 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td><strong>12 months</strong></td>
<td><strong>YES</strong></td>
<td><strong>YES</strong></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><strong>24 months</strong></td>
<td><strong>YES</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>30 months</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>3, 4, 5, and 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

Fax completed form to 512-458-7699, or mail to the address below.
### Risk Assessment for Lead Exposure: Parent Questionnaire

Healthcare Provider: For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.

#### Parent Questionnaire

<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 visit a home, daycare or other building built before 1978?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does your child live in or visit a home, daycare or other building with ongoing repairs or remodeling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 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>4. Does your child have a family member or friend who has or did have an elevated blood lead level?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is your child a newly arrived refugee or foreign adoptee?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is your child exposed to any of the following (if YES, check all that apply):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiator repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pottery making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead smelting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making fishing weights</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valve and pipe fittings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brass/copper foundry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refinishing furniture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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
- Foods canned or packaged outside the U.S.
- Remedies such as greta, azarcon, alarcon, alkol, balli golli, coral, ghasard, liga, pay-loo-ah, rueda

### 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) o visita una casa, centro de guardería u otro edificio construido antes de 1978?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ¿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>4. ¿Tienen parientes o compañeros de su hijo(a) que tienen o tuvieron altos niveles de plomo en la sangre?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. ¿Es su hijo recién refugiado o adoptado del extranjero?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. ¿Ha expuesto su hijo(a) a cualquier de los siguientes? (si SÍ, marque todos que apliquen):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sí “sí” o “no lo sé” Le 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 estas?

- Reparación de radiadores
- Construcción o reparación de casas
- Preparación de químicos
- Industria del plomo
- Quema de madera pintada con plomo
- Fundición de latón/cobre
- Fabricación de cerámica
- Fabricación o reparación de baterías
- Partes sueltas para tubos de cañerías y válvulas
- Soldadura
- Taller mecánico para autos o lote de chatarra
- Terminado de muebles
- Fabricación de pesas para pescar
- Ir a un campo de tiro o recargar balas
- Otros:
- 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, azarcon, alarcon, alkol, balli golli, coral, ghasard, liga, pay-loo-ah, rueda
- Pildoras alimenticias con excepción de las vitaminas
- Otros:

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

Texas Childhood Lead Poisoning Prevention Program
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Page 2 of 2 Revised 07/16/10
**A.5 Tuberculosis 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 years of age and 6 years of age, and once between 11 years of age and 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 client’s community may need to be added.

- If all the answers are unqualified negatives, the client 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 client should be tuberculin skin tested.
- In the case of the client 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 clients 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.
- clients 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 clients 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.
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 than 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?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>
<tr>
<td>Has your child been tested for TB? Yes___  (if yes, specify date <strong><strong>/</strong></strong>)  No___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your child ever had a positive TB skin test? Yes___  (if yes, specify date <strong><strong>/</strong></strong>)  No___</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For school/healthcare provider use only

PPD administered ________________________________

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     printed name

Provider phone number ___________________________________

City ________________________________________________ County __________________________

If positive, referral to healthcare provider Yes___   No___

If yes, name of provider ___________________________________
## Cuestionario 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 expelir 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 periodo 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>
<tbody>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su niño o niña nació en México o en cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, África, Europa Oriental o Asia durante el último año por más de 3 semanas?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿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?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente?</td>
<td>Sí (si sí, especifique la fecha <em><strong>/</strong></em>) No ___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina?</td>
<td>Sí (si sí, especifique la fecha <em><strong>/</strong></em>) No ___</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Se administró PPD?</td>
<td>Sí</td>
<td>No</td>
</tr>
</tbody>
</table>

Si sí, Fecha en que fue administrada ___/___/_____. Fecha de lectura ___/___/_____. Resultado de la prueba____ mm

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

Administrator de PPD ___________________________ ___________________________

Nombre en letra de molde (impronta)

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 clínica, etc.) ___________________________

EF12-11494A (Rev. 08/04)
CH.61 How to Determine TB Risk

Risk of potential tuberculosis exposure as revealed by questionnaire

YES
Past TB skin test

NO
No skin test

YES
Past TB skin test

NO
No skin test

(+) Positive
Skin test

(-) Negative
Has risk occurred since last negative skin test

(+/-) Positive
Skin test

(-) Negative
No further action

Clinical exam*

Symptoms of TB disease

YES
Therapy completed

NO
Clinical exam*

NO
Clinical exam*

Therapy completed

NO
Clinical exam*

No further action

* Clinical exam includes:
medical/social history
physician exam
chest x-ray
Consult physician/TB health experts about need for:
bacteriology
treatment
Infectious Disease Control Unit
PPD Agreement for Texas Health Steps Providers

Facility Name: ___________________________________________________________________________________
Address:  ______________________________________(City, State)___________________(Zip)____________
Provider Name: __________________________________________ Provider Title: ____________________________
Contact Name: __________________________________________   Contact Title: ____________________________
Contact Phone: __________________________________________     Contact Fax: ____________________________

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

Sign and Return to:

A copy of this agreement will be returned to you.

____________________________________________________________________   ________________
Health Department Representative Signature        Date

EF12-12105 PPD Agreement (Rev. 6/05)
CH.63  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:

Last Name  First Name  Mi

Child’s Date of Birth: _____/_____/_____

Parent/Guardian/Individual of Record:

Last Name  First Name  Mi

Provider’s/Clinic’s Name:

______________________________

Please select one of the following categories (check the first category that applies, check only one) to determine if the child is TVFC eligible:

☐ (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 a patient who receives benefits from the Children’s Health Insurance Plan (CHIP), or
☐ (f) 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
☐ (g) is a patient who is served by any type of public health clinic and does not meet any of the above criteria (a-f), or
☐ (h) has private insurance, or is paying for services.

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)
**CH.64 TVFC Patient Eligibility Screening Record (Spanish)**

**TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)**  
[EL PROGRAMA DE VACUNAS PARA LOS NIÑOS DE TEXAS,  
TVFC, por sus siglas en inglés]  
ARCHIVO QUE DETERMINA LA ELEGIBILIDAD DEL PACIENTE

Propósito: El determinar la elegibilidad y el origen de los fondos para rembolsar al Texas Department of State Health Services (Departamento Estatal de Servicios de Salud de Texas) por las vacunas. Un archivo debe guardarse en la oficina del proveedor de atención médica, el cual refleja el estatus de todos los niños de 18 años de edad o menores quienes reciben inmunizaciones a través del Programa de Vacunas Para los Niños de Texas. El formulario puede ser llenado por el padre, la madre, el tutor legal o el individuo del registro. Este mismo formulario puede utilizarse para todas las visitas subsiguientes con tal de que el estatus de elegibilidad del niño no haya cambiado. Aunque la verificación de las respuestas no es requerida, es necesario retener éste, o un archivo similar, para cada niño que reciba vacunas.

**Fecha de determinación:**

**Nombre del niño:**

<table>
<thead>
<tr>
<th>Apellido</th>
<th>Primer nombre</th>
<th>Inicial del segundo nombre</th>
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**Fecha de nacimiento del niño:**

<table>
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<th>(mes/día/año)</th>
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</thead>
</table>

**Padre / Madre / Tutor legal / Individuo del registro:**

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<tr>
<th>Apellido</th>
<th>Primer nombre</th>
<th>Inicial del segundo nombre</th>
</tr>
</thead>
</table>

**Nombre del proveedor / nombre de la clínica:**

Sirvase seleccionar una de las categorías siguientes (marque la primera categoría que se aplica; marque solamente una) para determinar si el niño cumple los requisitos para recibir vacunas del TVFC:

- [ ] (a) está inscrito en Medicaid, o
- [ ] (b) no tiene seguro médico, o
- [ ] (c) es Indio-Americano, o
- [ ] (d) es nativo de Alaska, o
- [ ] (e) es un paciente que recibe beneficios del *Children’s Health Insurance Plan* (Plan de seguro médico para niños, *CHIP*, por sus siglas en inglés), o
- [ ] (f) no tiene seguro médico suficiente (tiene seguro médico que NO paga por las vacunas; tiene un copago o un deducible que la familia no puede pagar; o tiene un seguro que proporciona una cobertura limitada para el bienestar o la prevención), o
- [ ] (g) es un paciente que recibe servicios de cualquier clínica de salud pública y no reúne ninguno de los criterios indicados anteriormente (a-f), o
- [ ] (h) tiene seguro privado o está pagando por servicios.

**Firma:**

**Fecha:**

Con pocas excepciones, usted tiene el derecho a pedir y ser informado(a) sobre la información que el Estado de Texas reúne sobre usted. Usted tiene el derecho a recibir y examinar la información al pedirlo. Usted también tiene el derecho a pedirle a la agencia estatal que corrija cualquier información que se determine ser incorrecta. Vaya a [http://www.dshs.state.tx.us](http://www.dshs.state.tx.us) para más información acerca de la Notificación sobre la Privacidad. (Referencia: *Government Code, Section 552.021, 552.023, 559.003 y 559.004*)
**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*

<table>
<thead>
<tr>
<th>Name of Facility, Practice, or Clinic:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name (M.D., D.O., N.P., P.A., or C.N.M.)*:</td>
<td></td>
</tr>
<tr>
<td>Contact: (Last Name) (First Name) (MI) (Title)</td>
<td></td>
</tr>
<tr>
<td>Mailing Address: (Last Name) (First Name) (MI) (Title)</td>
<td></td>
</tr>
<tr>
<td>Telephone Number: (City) (County) (Zip)</td>
<td></td>
</tr>
<tr>
<td>Address for Vaccine Delivery: (Street Address and Suite Number) (City) (Zip)</td>
<td></td>
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<tr>
<td>Fax Number:</td>
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</tbody>
</table>

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.

---

*Signature*  
(Date)

(Print Name and Title)

* A licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife must sign the TVFC Enrollment form.
**TEXAS VACCINES FOR CHILDREN PROGRAM**

**PROVIDER PROFILE FOR PIN ____ ____ ____ ____ ____**

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic? (Circle one) YES  NO

Type of Clinic: ( □ check one)
- Public Health Department/District
- Public Hospital
- Other Public Clinic
- Private Hospital
- Private Practice (Individual or Group)
- Other Private Clinic

**PATIENT PROFILE:**
Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12-month period.

<table>
<thead>
<tr>
<th>NUMBER OF CHILDREN IN EACH CATEGORY</th>
<th>&lt; 1 year old</th>
<th>1 - 6 years</th>
<th>7 - 18 years</th>
<th>Total</th>
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<tr>
<td>Enrolled in Medicaid.</td>
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<tr>
<td>Uninsured. (Note: Children enrolled in Health Maintenance Organizations are considered insured)</td>
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<tr>
<td>American Indians.</td>
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<tr>
<td>Alaskan Natives.</td>
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<td>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.)</td>
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<td>(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at public health clinics.</td>
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<td>Children who receive benefits from the Children’s Health Insurance Plan (CHIP).</td>
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<td>Children who are vaccinated in your practice, but are NOT TVFC-eligible.</td>
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<td>TOTAL PATIENTS: (Add columns)</td>
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**TEXAS VACCINES FOR CHILDREN PROGRAM PROVIDER LIST**

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

<table>
<thead>
<tr>
<th>Last Name (List provider who signed Provider Enrollment Form first)</th>
<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>
<th>Medical License Number</th>
<th>Specialty (Family Medicine, Pediatrics, etc.)</th>
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Texas Department of State Health Services  
Immunization Branch  

Stock Number E6-102  
Revised 12/2007
## TEXAS VACCINES FOR CHILDREN PROGRAM

**PROVIDER LIST-ADDENDUM FOR PIN ______ ______ ______**

<table>
<thead>
<tr>
<th>Last Name (List provider who signed Provider Enrollment Form first)</th>
<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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Please list all individuals within the practice who will be administering TVFC supplied vaccine.
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.