

FORM

Child Non-Emergency Medical Check-up Form / Formulario de Chequeo Médico Preventivo para Niños(as)

Program Year / Año del Programa: September 2008–August 2009/Septiembre 2008-Agosto 2009

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|--|-----------------------------------|-------------------------------------|--|
| Patient Name / Nombre del Paciente: | DOB / Fecha de Nacimiento: | Patient # / No del Paciente: | Date of Visit / Fecha de la Visita: |
| | | | |

Screenings / Chequeos

| CONDITIONS / AFECIONES | GUIDELINES / INSTRUCCIONES | COMPLETION STATUS / ESTADO FINALIZADO |
|---|---|--|
| FOR AGES 0-5 / PARA EDADES DE 0-5 | | |
| Developmental Assessment (e.g. Ages and Stages) | Assess annually For screen (+), refer children < 30 months to Early Intervention (EI) | <input type="checkbox"/> Assessment completed <input type="checkbox"/> Referred to EI |
| Lead Exposure Screen | Measure at annual visit for 1 & 2 yrs and assess risk of lead exposure annually until age 6 | <input type="checkbox"/> Screening/assessment completed |
| Body Mass Index (BMI) (Discuss fitnessgram) | Measure at every annual visit | <input type="checkbox"/> Screening completed |
| Routine physical | Complete at annual visit | <input type="checkbox"/> Physical completed |
| FOR AGES 6-12 / PARA EDADES DE 6-12 | | |
| Body Mass Index (BMI) (Discuss fitnessgram) | Measure at every annual visit | <input type="checkbox"/> Screening completed |
| Routine physical | Complete at annual visit | <input type="checkbox"/> Physical completed |
| FOR AGES 13-19 / PARA EDADES DE 13-19 | | |
| Body Mass Index (BMI) (Discuss fitnessgram) | Measure at every annual visit | <input type="checkbox"/> Screening completed |
| Reproductive Health Counseling | Counseling, referral, prescribing and dispensing of contraceptives and screening for STIs | <input type="checkbox"/> Counseling completed |
| Routine physical | Complete at annual visit | <input type="checkbox"/> Physical completed |

Immunizations Review / Revisión de Inmunizaciones

Discussed immunization status and made appropriate recommendations

Recommended Follow-Up Visit / Visita de Seguimiento Recomendada (With current doctor or other specialist / con el médico actual u otro especialista)

| | |
|--|---|
| Next visit should occur in: <input type="checkbox"/> 3 Months <input type="checkbox"/> Up to 6 Months <input type="checkbox"/> Up to 1 year | Next annual preventive exam: <input type="checkbox"/> 1 year |
|--|---|

Doctor's Information / Información del Médico

NAME / NOMBRE: _____ **SIGNATURE / FIRMA:** _____
LICENSE # / NO. DE LICENCIA: _____
OFFICE OR CLINIC NAME / OFICINA O NOMBRE DE LA CLINICA: _____
STREET ADDRESS / DIRECCIÓN: _____
CITY, STATE, ZIP / CIUDAD, ESTADO, CODIGO POSTAL: _____
TELEPHONE NUMBER / NÚMERO TELEFÓNICO: _____ **EMAIL:** _____