

**WELL CHILD EXAM
EARLY CHILDHOOD:
15 MONTHS**

Authority: P.A. 116 of 1973
Completion: Required
Consequences of non-completion:
Non-compliance of licensing rules.

Michigan Department of Human Services

Well Child Exam Date		Patient Name		DOB	Sex	Parent Name				
Allergies					Current Medications					
Prenatal/Family History										
Weight	Percentile %	Length	Percentile %	Wt. for length Percentile %	HC	Percentile %	Temp.	Pulse	Resp.	BP (if risk)

<p>Interval History: (Include injury/illness, visits to other health care providers, changes in family or home)</p> <p>Nutrition</p> <p><input type="checkbox"/> Whole milk, cup only</p> <p><input type="checkbox"/> Solids _____ servings per day</p> <p><input type="checkbox"/> City water <input type="checkbox"/> Well water</p> <p>WIC <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Elimination <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Sleep</p> <p><input type="checkbox"/> Normal (8 – 12 hours) <input type="checkbox"/> Abnormal</p> <p>Additional area for comments on page 2</p> <p>Screening and Procedures</p> <p><input type="checkbox"/> Subjective Hearing – Parental observation/ concerns</p> <p><input type="checkbox"/> Subjective Vision – Parental observation/ concerns</p> <p>Developmental Surveillance</p> <p><input type="checkbox"/> Social-Emotional <input type="checkbox"/> Communicative</p> <p><input type="checkbox"/> Physical Development <input type="checkbox"/> Cognitive</p> <p>Psychosocial/Behavioral Assessment</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Screening for Abuse</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Immunizations:</p> <p><input type="checkbox"/> Immunizations Reviewed, Given & Charted – if not given, document rationale</p> <p><input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB</p> <p><input type="checkbox"/> Flu <input type="checkbox"/> MMR HepA</p> <p><input type="checkbox"/> Varicella or Chicken Pox Date _____</p> <p><input type="checkbox"/> MCIR checked/updated</p> <p><input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours</p>	<p>Patient Unclothed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Review of Systems</th> <th colspan="2">Physical Exam</th> <th rowspan="2">Systems</th> </tr> <tr> <th>N</th> <th>A</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Appearance</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin/nodes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Head/fontanel</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eyes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ears</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nose</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Oropharynx</td></tr> <tr><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neurological</td></tr> </tbody> </table> <p><input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page</p> <p>Results of visit discussed with parent <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Plan</p> <p><input type="checkbox"/> History/Problem List/Meds Updated</p> <p><input type="checkbox"/> Fluoride Varnish Applied</p> <p><input type="checkbox"/> Referrals</p> <p><input type="checkbox"/> WIC <input type="checkbox"/> Early On</p> <p><input type="checkbox"/> Children Special Health Care Needs</p> <p><input type="checkbox"/> Transportation <input type="checkbox"/> Dentist</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p>	Review of Systems	Physical Exam		Systems	N	A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	<input type="checkbox"/>	<input 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liquids and matches out of reach</p> <p><input type="checkbox"/> Avoid TV viewing</p> <p>Oral Health</p> <p><input type="checkbox"/> Brush toddler's teeth with soft toothbrush/water twice daily</p> <p><input type="checkbox"/> Make first dental appointment if not done yet</p> <p><input type="checkbox"/> Use good family oral habits</p> <p><input type="checkbox"/> Don't share utensils or cups</p> <p>Sleep Routines and Issues</p> <p><input type="checkbox"/> Bedtime Routine</p> <p><input type="checkbox"/> Strategies for night waking</p> <p><input type="checkbox"/> Don't put to bed with bottle</p> <p>Child Development and Behavior</p> <p><input type="checkbox"/> Stranger anxiety and separation anxiety</p> <p><input type="checkbox"/> Promote child's language by using simple clear words and phrases</p> <p><input type="checkbox"/> Allow child choices acceptable to you</p> <p><input type="checkbox"/> Speak to your child reassuringly</p> <p><input type="checkbox"/> Use distraction e.g. an alternative activity</p> <p><input type="checkbox"/> Praise good behavior and activities</p> <p><input type="checkbox"/> Use discipline tot each, not punish</p> <p>Family Support and Relationships</p> <p><input type="checkbox"/> Keep family outings short and simple</p> <p><input type="checkbox"/> Help child express emotions appropriately</p> <p><input type="checkbox"/> Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression</p> <p>Other Anticipatory Guidance Discussed:</p>
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		Next Well Check: 18 months of age				Developmental Surveillance on Page 2 Page 3 required for Foster Care Children																																																																		
		Medical Provider Signature:																																																																						

**PAGE 2 – WELL CHILD EXAM – EARLY CHILDHOOD: 15 MONTHS
DEVELOPMENTAL SURVEILLANCE**

(This page may be used if not utilizing a Validated Developmental Screener)

Date	Patient Name	DOB
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Developmental Questions and Observations

Ask the parent to respond to the following statements about the toddler:

Yes No

- Please tell me any concerns about the way your toddler is behaving or developing

- My toddler likes to be with me.
- My toddler is interested in people, places and things.
- My toddler shows different feelings.
- My toddler feeds self with fingers/spoon and drinks from a cup.
- My toddler can stack 2-3 blocks.

Ask the parent to respond to the following statements:

Yes No

- I am sad more often than I am happy.
- I have people who help me when I get frustrated with my toddler.
- I am enjoying my time with my toddler.
- I have time for myself, partner and friends.
- I feel safe with my partner.

Developmental Milestones

Always ask parents if they have concerns about development or behavior. A standardized developmental and autism screening tool should be administered (Medicaid required) at the 18 month visit. If the child is unlikely to return for an 18 month visit, the standardized screens should be completed at the 15 month visit. In addition, the following should be observed:

Toddler Development	Yes	No	Parent Development	Yes	No
Understands simple commands	<input type="checkbox"/>	<input type="checkbox"/>	Appropriately disciplines toddler	<input type="checkbox"/>	<input type="checkbox"/>
Walks without support	<input type="checkbox"/>	<input type="checkbox"/>	Positively talks, listens, and responds to toddler	<input type="checkbox"/>	<input type="checkbox"/>
Says at least 3 – 5 words	<input type="checkbox"/>	<input type="checkbox"/>	Parent is loving toward toddler	<input type="checkbox"/>	<input type="checkbox"/>
Indicates wants by pointing or gestures	<input type="checkbox"/>	<input type="checkbox"/>	Uses words to tell toddler what is coming next	<input type="checkbox"/>	<input type="checkbox"/>
Is able to transition from one activity to another throughout the day	<input type="checkbox"/>	<input type="checkbox"/>			
Appears to have a secure and attached relationship with parent	<input type="checkbox"/>	<input type="checkbox"/>			

Please note: Any concerns raised during surveillance should be promptly addressed with standardized developmental screening tests. In addition, screening tests should be administered regularly at the 9-, 18-, and 24- or 30-month visits (AAP, 2006, Identifying Infants and Young Children with Developmental Disorders in Medical Home: An Algorithm for Developmental Surveillance and Screening)

Additional Notes from pages 1 and 2:

Medical Provider Signature	Medical Provider Name (please print)
Address	Telephone Number

**THIS PAGE IS REQUIRED FOR FOSTER CARE CHILDREN
WELL CHILD EXAM – EARLY CHILDHOOD: 15 Months**

Date	Child's Name	DOB
Name of person who accompanied child to appointment	<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Relative Caregiver (specify relationship) <input type="checkbox"/> Caseworker	
Phone number of person who accompanied child to appointment		

Physical completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements

Yes Please attach completed physical form utilized at this visit

No If no, please state reason physical exam was not completed _____

Developmental, Social/Emotional and Behavioral Health Screenings

Always ask parents or guardian if they have concerns about development or behavior. (You must use a standardized developmental instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening completed: Date _____

Screener Used: ASQ ASQSE PEDS PEDSDM Other tool: _____ Score: _____

Referral Needed: No Yes

Referral Made: No Yes Date of Referral: _____ Agency: _____

Current or Past Mental Health Services Received: No Yes (if yes please provide name of provider)

Name of Mental Health Provider: _____

EPSDT Abnormal results:

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.):

Medical Provider Signature	Medical Provider Name (please print)
Address	Telephone Number

This HME form was developed by the Institute for Health Care Studies and Michigan State University in collaboration with the Michigan Medicaid managed care plans. Michigan Department of Community Health, Michigan Department of Human Services, Michigan Association of Health Plans, and Michigan Association of Local Public Health.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Provide child's caregiver/foster parent with handout.

PARENT/CAREGIVER HANDOUT

Your Child's Health at 15 Months

Milestones

Ways your child is developing between 15 and 18 months of age

- Says phrases of at least two words
- Walks, may run a bit, climbs up or down one stair
- Likes pull toys and likes being read to
- Is curious and likes to explore people, places and things
- Protests and says, "NO!"
- Imitates others
- Kisses and shows affection
- Makes marks with a crayon

For Help or More Information:

Care seat safety:

- Contact the Auto Safety Hotline at 1-888-327-4236 or online at www.nhtsa.dot.gov
- To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at www.seatcheck.org

For information about childhood immunizations:

Call the National Immunization Program Hotlines at 1 (800) 232-4636 or online at <http://www.cdc.gov/vaccines>

For information about lead screening:

Visit the Michigan Bridges 4 Kids lead website at www.bridges4kids.org/lead.html or contact the Childhood Lead Poisoning Prevention Project at (517) 335-8885

Poison Prevention:

Call the Poison Control Center at 1-800-222-1222 or online at www.mitoxic.org/pcc

If you're concerned about your child's development:

Contact Early On Michigan at 1-800-327-5966 or Project Find at <http://www.projectfindmichigan.org/> or call 1-800-252-0052

Parenting skills or support:

Call the Parents HELpline at 1-800-942-4357 or the Family Support Network of Michigan at 1-800-359-3722.

For families of children with special health care needs:

Children Special Health Care Services, Family phone line at 1-800-359-3722 or www.mdch.state.mi.us/msa/mdch_msa/cshcs.htm

Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or www.safekids.org

Domestic Violence hotline:

National Domestic Violence Hotline – (800) 799-SAFE (7233) or online at www.ndvh.org

Health Tips

Your child's check-ups will be spaced farther apart as your child gets older. If you have concerns between checkups, be sure to call the doctor or nurse and ask questions.

Check to make sure your child has had all the shots he needs. If your child has missed some shots, make an appointment to get them soon. Your child needs all the required shots to have the best protection against serious diseases.

Your child's appetite may be less than in the past. Offer a variety of healthy foods. Let her decide how much of each food to eat. Do not force her to finish food.

Your child needs two cups of milk or yogurt or three slices of cheese each day. Avoid low-fat foods until age 2.

Each child develops in his own way, but you know your child best. If you think he is not developing well, you can get a free screening. Call your child's doctor or nurse if you have questions.

Parenting Tips:

Name your child's feelings out loud – happy, sad or mad. Use words to tell her what is coming next. Your child can understand more words than she can say. Give your child simple choices. Example "squash or peas?"

Calmly set limits for your child by giving him something different to do. Praise him when he does things that you like.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1-800-942-4357 (in Michigan). They will not ask your name and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

Safety Tips

Falls often cause young children to get hurt. Take your child to a safe playground. Find one that has padding, sand, or wood chips under the toys. Look for small toys that fit a toddler. Stay close to your child while they are playing.

Your child may try to get out of her car seat. Avoid letting her get out, because then she will try again and again.

- If she tries, be firm, stop the car and refuse to move until she stays buckled in.
- Take soft toys, picture books, and music to entertain your child in the car.
- Wear your own seat belt, too.

From the Institute for Health Care Studies at Michigan State University.

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