If delay suspected, specify below

**/H18554**

**DEVELOPMENTAL**

Does the child/adolescent have a past or present medical history of the following?
- Uncomplicated
- Premature: weeks gestation
- Complicated by
- Allergies
- None
- Epi pen prescribed
- Gold (list)
- Drugs (list)
- Foods (list)
- Other (list)

**Screening Tests**

<table>
<thead>
<tr>
<th>Blood Lead Level ( BLL) (required at age 1 yr and and for those at risk)</th>
<th>Date Done</th>
<th>Results</th>
<th>Date Done</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotate ( age 18 months)</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
<td>________</td>
</tr>
<tr>
<td>Lead Risk Assessment ( annually, age 6 mo-6 yrs)</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
<td>________</td>
</tr>
<tr>
<td>Hearing</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
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<tr>
<td>OAE</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
<td>________</td>
</tr>
<tr>
<td>Hemoglobin or Hematocrit (age 9-12 mos)</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
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</tr>
<tr>
<td>Head Start Only</td>
<td>__________</td>
<td>________</td>
<td>__________</td>
<td>________</td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS – DATES**

| DTP/DtaP/DT                                                    |__________| ________|__________| ________|
| Rotavirus                                                     |__________| ________|__________| ________|
| Hib                                                           |__________| ________|__________| ________|
| PCV                                                           |__________| ________|__________| ________|
| Polio                                                         |__________| ________|__________| ________|

**Recommendations**

- Full physical activity
- Full diet

**Assessment**

- **Well Child (V20.2)**
- Diagnoses/Problems (list)

**ICD-9 Code**

- None
- Yes (if PPD or Interferon positive)
- Chest x-ray
  - N/A
  - Not
  - Indicated

**Dietary Restrictions**

- None
- Yes (list below)

**Healthcare Provider Signature**

- Date

**DOHMH PROVIDER ID**