MCH/HEALTH TRACKS PEDIATRIC ASSESSMENT FORM (SFN 1819) GUIDELINES

Statement of Intent: This form is to be used to record infant/child/young adult (ages 0 - 21) physical assessment. A new record is required for each assessment. **All blank spaces must be coded.** This form may be used for a variety of pediatric health programs, (i.e., North Dakota Health Tracks (EPSDT), Head Start, CHNC, etc.).

Resource: See Section 1 (Pediatric Assessment) of the Child Health Services Manual.

Date of Screening: Self-explanatory
MA I.D. No: List complete Medicaid identification number
Program: Program for which infant/child/young adult is being assessed.

Demographic Data:

Name: First and last name plus middle initial
Date of Birth: Birth date
Race: Document race(s)
Sex: Gender
Age at Visit: Document age
Accompanied By: Name of person accompanying infant/child/young adult and relationship
Recent Illness/Accidents/Medicines/Prenatal Concerns: Brief update of any changes
Telephone Number: Family telephone number(s) where parent or guardian can be reached
Parent's or Guardian's Names: Self-explanatory
Parent's or Guardian's Address: Self-explanatory

I. Health Information:

Height/%: Actual height and percent. Record on growth chart for age found at www.cdc.gov/GrowthCharts
Weight/%: Actual weight and percent. Record on growth chart.
BMI/%: Actual BMI and percent for children two years and older.
Head Circumference/%: Use growth chart for age.
Tobacco Exposure/Use: Answer the four tobacco questions with "yes" or "no". Note referral in comment section
Blood Pressure: Three years and older. Use information in Child Health Services Manual, Section 1, Appendix 3.
TPR: Temperature, pulse (apical or radial) and respiration. Use information in Child Health Services Manual, Section 1, Subject 3, Pages 1-3.
Hgb: Hemoglobin. Refer to Child Health Services Manual, Pediatric Assessment Section 1, Appendix 15 and 15A.
UA: For UA document positive findings or referral key code 5 for negative finding and note referral in comment section.
Lead Screening: Use coding system (Not Applicable, Blood Draw, Questionnaire). Refer to guidelines in Child Health Services Manual, Section 2, Appendices 17 and 18 and Subject 7.

Coding for Use in Review of Systems and Physical Assessment:

1. Positive findings - refer for Diagnosis & Treatment: Use #1 for any positive findings on systems review or physical assessment which are referred for diagnosis and treatment (i.e., otitis media, hearing impairment, lack of visual acuity, etc.).
2. Positive findings - no referral, under treatment: Use #2 if child has a positive finding which has already been diagnosed and already receiving treatment (i.e., conjunctivitis or impetigo and already on an antibiotic, etc.).
3. Positive findings - parent/recipient refused referral: Use #3 for those instances when a referral for a positive finding is refused by family or recipient.
4. Screening not completed - parent/recipient refused exam: Use #4 when screening is not completed. This may be due to uncooperative child, screening not required at this time, or refusal by parent or recipient to complete exam, etc.
5. Negative findings: Use #5 when no positive findings are detected on systems review or physical assessment.

6. Positive results - treated on-site: Use #6 when positive findings are resolved on site, (i.e., needed immunization given).
7. Anticipatory Guidance/Education: Use #7 when caregiver receives anticipatory guidance from nurse under related category, (i.e., skin care, prevention of communicable disease, etc.).
8. See comments: Use #8 when additional information needs to be recorded on nurses' intervention sheets. Number 8 could be used with other code numbers.

II. Review of Systems:

The review of systems is done to elicit any information concerning potential health problems the infant/child/young adult may have. The nurse may need to explain to the caregiver that some questions will be asked prior to initiating the physical assessment. This will give the nurse a more complete health picture of the infant/child/young adult. Interviewing is most efficient if a combination of open ended or fact-finding questions is used, (i.e., “How has your child's general health been?” or “Has your child had any problems with their eyes?”). We can also use encouraging statements such as “Tell me more about that.” Whenever possible, questions should be directed to the child/young adult.

General: Abnormalities noted (i.e., allergies, fever, fatigue, increase or decrease in weight, eating disorders, small or large for age, anemia, failure to thrive, etc.). For hemoglobin (HGB), mark “NA” if normal and “referral” if abnormal and further follow up is needed. If treated on-site, explain in the comment section below.

Eyes: Abnormalities noted (i.e., crossed, squints, blurred vision, redness, discharge, blocked tear ducts, etc.). Document any vision screening results (i.e., Snellen E Chart, Keystone Telebinocular, Color Blindness Testing, etc.).

ENT/Mouth: Information regarding ears, nose or throat (i.e., sore throat, tonsillitis, otitis media, sinus problems, nasal discharge, condition of teeth/gums, thrush, etc.). Document results of any hearing tests here.

Dental Screening: Mark the dental questions with a “Yes” or “No”. For orthodontic, mark “NA” if child is less than 6.5 years (unless otherwise indicated). Mark “referred” if abnormal and further follow up is needed. Mark “yes” or “no” if fluoride varnish was applied today. Note the date if fluoride varnish was applied previously. Refer to Child Health Services manual, Section 1 and 2. Refer to Healthy Smiles-Fluoride Varnish Program manual for additional information on fluoride varnish.

Resp./Cardiac: Information related to respiratory or cardiac systems (i.e., cough, wheezes, asthma, pneumonia, shortness of breath, bronchitis, RSV, elevated blood pressure, cyanosis, murmur, etc.).

GI: Information related to GI system (i.e., no problem, constipation, diarrhea, vomiting, abdominal pain, parasites, etc.).

GU/Reproductive: Information related to GU system (i.e., nausea, burning or frequency on urination, frequent urinary infections, blood in urine, enuresis, age menses started [any difficulties], last menstrual period, hernia, hydrocele, etc.). For “UA” use “referral key code” and note referral in comment section.

Musculoskeletal: Information related to musculoskeletal system, (i.e., muscle weakness, floppy, rigid, cramps, clumsy, joint pain, growing pains, scoliosis, gait, fractures, sprains, etc.).

Skin: Information related to skin, (i.e., rashes, bruising easily, sores, allergies, parasites [scabies or head lice], acne, birthmarks, moles, tattoos, piercings, etc.).

Neuro: Information related to neurological system, (i.e., head trauma, headaches, seizures, lead exposure, tremors, tics, dizziness, etc.). Also consider “soft signs,” inability to perform certain activities related to the child's ages that provide clues to an underlying central nervous system deficit or neurologic maturation delay (i.e., short attention span, poor coordination, labile, no established handedness).

Endocrine: Information related to endocrine system, (i.e., diabetes, thyroid, heat or cold intolerance, increased thirst, hunger or changes in urination, glandular growth problems, etc.).

III. Physical Assessment:

Use Code and document additional information related to abnormal findings under Comments section.

Head: Assess head and face for shape, posture, symmetry, bumps, bruises or abnormalities. In infants, check head control and fontanel.
Neck: Palpate neck for any masses, enlarged lymph nodes, position of thyroid cartilage and trachea. Observe neck for range of motion.
Eyes: Examine eyes for size, symmetry, color and motility. Observe placement and alignment of the eyes on face and observe external structure of the eye.
Ears: Observe external ears for alignment, symmetry, tags, drainage, foreign objects, etc. Inspect internal ear with otoscope.
Nose: Observe external nose for shape, symmetry, abnormalities, drainage, foreign objects, etc. Inspect for presence or absence of fulcrum. (May be absent or very flat in FAS/FAE). Internal nares may be examined with the otoscope.
Mouth/Dental: Begin inspection of the mouth by observing lips for color, dryness, sores, etc. Inspect mouth for any abnormalities. Check infants for thrush. Note any mouth odor and check gums for signs of inflammation/infection. Check teeth for number, caries and malocclusion (See Appendix 5).
Throat: Size and color of the tonsils, uvula, inflammation, white patches, etc.
Chest: Inspect the chest for size, shape, symmetry, movement and Tanner Stages of Breast Development (See Section Subject 6, Page 8 of 22).
Heart: Auscultate heart sounds, rate and rhythm.
Lungs: Auscultate lung sounds, rate and rhythm.
Abdomen: Examine abdomen for size, shape, color, scars, hernia, etc. Palpate for signs of tenderness, masses, enlarged organs, etc.
Genitalia: Examine genitals for any abnormalities, redness, inflammation, presence of testes, location of urethra, Tanner Stages of Development, etc. (See this Section, Subject 6, Page 12 of 22).
UA: For UA use "referral key code" and note referral in comment section. Abnormalities should be noted in the comment section.
Spine: Assess spine for any abnormalities; observe for scoliosis Refer to Child Health Services manual, Section 1, Appendix 8.
Limbs: Observe limbs and gait for any abnormalities such as range of motion, reflexes, hip dysplasia, toeing in, knock kneed, etc.
Skin: Assess skin for color, temperature, moisture, bruises, infections, etc.
Neurological: Observe for any neurological function/abnormality of cranial nerves and reflexes (Refer to Subject 6, Pages 14-18).
Immunizations: Assess immunization status. Update and document.
Dental Screening: Answer the two dental questions with a "Yes" or "No."
Nutrition: Determine if child is on WIC. If not on WIC but meets criteria, refer. Provide nutritional education. To enhance nutrition assessment, See Appendix 7-14F.
Social/Emotional Screen: For Social/Emotional Screen use "referral key code."

- Development
- Mental
- Speech

Comments: List additional information.

Signature: Full Name and Title of Health Tracks Coordinator and Full Name and Title of Screening Medical Provider.

Date: Day, month and year form completed.