Patient intake for 12 MONTH HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Visit Related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:
Verbal Sign language Written Assistive Communication Device

Preferred method of learning:
Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:
No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.
If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

◆ Do you suspect your baby is in pain? **Staff- Evaluate pain with FLACC Tool***	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____	(◆ **Staff- Request Records*)**	

Review of Symptoms (Place an "X" in all categories that apply):

Poor weight gain		Fever		Cough	
Hearing concerns		Headache		Wheezing	
Vision concerns		Sinus Congestion Present		Vomiting	
Difficulty Breathing		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in bowel habits		Pulling on Ears		Decreased Appetite	
Sweating with feeds		Ear Drainage		Other:	
Rash		Sore Throat			

Family Screening

Are any members of the household currently deployed or on extended duty outside of the immediate area?	**YES**	**NO**
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	**YES**	**NO**

Nutrition

Feeding Method?

Breast Bottle Sippy/Straw Cup Spoon/Fork Other_____

Feeding Type?

Breastmilk Formula Whole Milk 2% Solids

Tuberculosis (TB) Screen

Has a family member or contact had active tuberculosis? Yes. No.
Has a family member had a positive tuberculin skin test? Yes. No.
Was your child born in a high-risk country? Yes. No.
Has your child traveled to a high risk country for more than one week? Yes. No.

Lead Screen

- What is your child's primary address?_____
- Has a sibling or playmate had lead poisoning? Yes. No. Don't Know.
- Does your child reside in or visit a house or childcare facility built before 1978 which has peeling or chipping paint or has been renovated or remodeled within the last 6 months? Yes. No. Don't Know.
- Does your child come in contact with an adult whose job or hobby involves lead exposure (firing range, metal work, mining, stained glass work, renovation/remodeling)? Yes. No. Don't Know.
- Does your child ive in a household eligible for Medicaid, WIC, CHIP, or a state benefits program? Yes. No. Don't Know.
- Is your child a newly arrived refugee, immigrant, or a foreign adoptee? Yes. No. Don't Know.

❖ Corpsmen: check lead exposure risk zone based on address at: https://fortress.wa.gov/doh/wtnibl/WTNIBL/ NOTIFY PROVIDER DURING TURNOVER of any "Yes" or "Don't Know" answers for TB or Lead Screens.

Developmental Milestones

Uses "mama" or "dada" for specific parents?	YES	NO
Takes first independent step or stands w/ support?	YES	NO
Uses gestures (waving "bye", shaking head for "no", etc.)	YES	NO
Bangs objects together?	YES	NO
Walks holding onto furniture?	YES	NO
Cries when caregivers leave?	YES	NO
Points to objects?	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	**YES**	**NO**

Family history/Surgeries. Check all that apply.

Family History	**Patient** Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
♦To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend Daycare?	YES	NO

<u>You are DONE! Please keep your paperwork with you and wait to be called back.</u>

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****

(Below for Office Staff)

Weight: _____kg

Length: _____cm

Head Circumference: _____cm

Heart Rate: _____ bpm

Lead Exposure Risk Zone: _____

Respiratory Rate: _____ breaths/min

O2 sat (if indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

12 Month Health Supervision

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process

Click on me to go to the "**HealthyChildren.org**" Website! An American Academy of Pediatrics (AAP) guide to your child's milestones, growth and development. Search by age.

Your child's growth:

Weight:_____lb. Percentile:_____

Length: _____in. Percentile:_____

Head Circumference:_____cm. Percentile:_____

Feeding

- Continue breastfeeding for as long as desired.
- Can stop giving formula.
- Can now give cow's milk- limit to 24 oz per day and try to give mostly with meals.
- Continue to give 3 meals and 2-3 snacks per day.
- Avoid foods that may cause choking (peanuts, hot dogs, popcorn, raw carrots)

Your Changing Baby

- Follow a regular bed-time routine and schedule. Minimize interaction with baby at night during awakenings.
- Avoid the use of computers, TV, or videos
- Sing, speak and read to your baby often.
- Show and tell your baby what you want them to do.
- Start brushing teeth twice daily. Only give water after brushing teeth at night.

Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Keep hanging cords or strings away from your baby.
- Keep a hand on your baby when changing clothes or the diaper.
- Never leave your baby alone near water.
- Do not use a baby walker.
- Place gates on stairs.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

Immunizations

- MMR #1 (Measles, Mumps, Rubella)
- Varivax #1 (Varicella)
- VAQTA #1 (Hepatitis A)
- Annual Influenza (2 doses for first time influenza vaccination)

Laboratory

- Anemia screening
- Lead testing (if ordered by your physician/provider)

When to call the doctor?

- Call the TRICARE Nurse Advice Line 1-800-TRICARE (1-800-874-2273)
- Use the "Wait, Worry, Panic" online guide from Center City Pediatrics: https://centercitypediatrics.com/wait-worry-panic/

Next health supervision appointment: 15 months of age.

Patient specific guidance:

_____

_____