

Patient intake for 15 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 toddler is in pain?
Staff- Evaluate pain with FLACC Scale*

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 <u>deployed</u> or on <u>extended duty</u> 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 Spoon/Fork Sippy Cup/Straw Other _____

Feeding Type?

Breastmilk Formula Whole Milk 2% Solids Other: _____

Oral Health

In what city & county does your child live? _____

Do you have any concerns about your child's oral health? YES NO

Has your child had a dental cleaning/check-up? YES NO

Do you brush your child's teeth using fluoride toothpaste? YES NO

Developmental Milestones

Walks unassisted?	YES	NO
Understands & follows simple commands (ie: "get the ball"?)	YES	NO
Drinks from a cup with little spilling?	YES	NO
Listens to a story?	YES	NO
Brings and shows toys?	YES	NO
Regularly uses 3 words?	YES	NO

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO
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Family history/Surgeries. Check or circle 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

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

***** 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 programs for recognition! *****

(Below for Office Staff)

Weight: _____ kg

Respiratory Rate: _____ breaths/min

Length: _____ cm

O2 sat (if indicated): _____

Head Circumference: _____ cm

Temperature: _____

Heart Rate: _____ bpm

(Temporal, oral, tympanic, axillary, rectal)

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

15 Month Health Supervision

Your child's growth:

Weight: _____ lb. Percentile: _____
Length: _____ in. Percentile: _____
Head Circumference: _____ cm. Percentile: _____

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.



Feeding

- Limit milk 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 Toddler

- Follow a regular bed-time routine and schedule. Minimize interaction with toddler at night during awakenings.
- Avoid the use of computers, TV, or videos
- Sing, speak and read to your toddler often.
- Show and tell your toddler what you want them to do.
- Use distraction to stop tantrums when you can.
- Limit the need to say "No" by making your home and yard safe for play.
- Let your child choose between 2 good things for food, drinks, or books.
- Brush teeth twice daily. Only give water after brushing teeth at night.
- Take your child for a first dental visit if you have not done so.

Safety

- Use a rear-facing car safety seat in all vehicles until age 2 years old.
- Never put your toddler in the front seat of a vehicle with a passenger air bag.
- Keep your car and home smoke free.
- Never leave your toddler alone near water.
- Place gates on stairs.
- Lock up poisons, medicines, and cleaning supplies. Call Poison Control at 1-800-222-1222 if you need them.

Immunizations

- Infanrix (Diphtheria, Tetanus, Pertussis) #4
- Pedvax #3 (Haemophilus Influenza Type B)
- Prevnar 20 #4 (Streptococcal pneumoniae)
- Annual Influenza (2 doses for first time influenza vaccination)

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: 18 months of age.

Patient specific guidance:

Pediatric Appointment Reminder

To expedite your visit, please visit this link:

<https://bremerton.tricare.mil/Health-Services/Childrens-Health/Pediatrics>

OR

Scan this QR code to **fill out the intake paperwork required for your appointment.**

You can bring a printed copy or send it to us electronically via the Patient Portal.

Date: _____ Time: _____

Appointment for: _____

Location: Pediatric Clinic, Bldg 17, 3rd floor

Instructions:

- Arrive to your appointment 10 min early
- Please call the PEDS Clinic with any questions or concerns: 360-475-4236

