SAMPLE

Inland Empire Health Plan

Pediatrics- Required Documentation Check List (Birth to 20 y.o.)

May place one in each Pediatric record to remind you of the required items during your medical record audit.

Patient Name: _____ **Date:** _____

Allergies: _____ ☐ NKA **Reactions to allergies**: _____

Emergency Contact #: _____ **Name**: _____
(***MUST*** be parent or legal guardian)

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ **Interpreter required?** ☐ Yes ☐ No

Person/Entity Providing medical interpretation is identified: _____

Signed Copy of the Notice of Privacy: ☐ Yes ☐ No **Consent for Treatment:** ☐ Yes ☐ No

Release of Medical Records: ☐ Yes ☐ No ☐ NA

Advanced Directive Education (For ages 18 yrs or older)**:** ☐ Yes ☐ No ☐ Refused **Date:** _____

Date last Well Child Exam and interval history (completed per AAP: birth, 2 months, 4,6,9,12,15,18,24,30, 3Y, then annually) _____

Developmental Surveillance: _____ (age appropriate, completed at every well care visit)

Developmental Disorder Screening Done at: ☐ 9th **Date:** _____ ☐ 18th **Date:** _____
☐ 30th **Date:** _____ month visits

Alcohol/Drug Misuse: Screening & Behavioral Counseling: _____

Anemia Screening: ____ (performed at 4,15,18,24,30 months & 3 yrs then annually thereafter & serum Hgb at 12 months)

Autism Spectrum Disorder Screening: (performed at 18 months and 24 months): _____

Date Nutritional Screening/ Breast feeding support: _____ (includes ht/wt, Hct or Hgb, food identifications form or dietary review.)

Blood Lead testing: _____ (at 12 and 24 months)

Date ht/wt graphed: _____ (**Obesity Screening**) **BMI % graphed:** _____

Blood pressure: _____ (3yrs & older)

(Length/Height and weight are documented and plotted on World Health Organization (WHO) growth chart for ages 0-2 and CDC growth chart for children 2 years and older)

Date TB Risk Assessment: _____ (with each WCC or Tb skin test, CXR, or Quantiferon Gold)

Date Anticipatory Guidance/Education evaluated: _____ (age appropriate)

Date Vision Screening: _____ (<3 yrs documentation of assessment, 3 yr or > vision testing)

Date Hearing Screening: _____ (<4 yrs documentation of assessment, 4 yrs or> hearing testing)

Date of Dental Assessment: _____ (Inspection of the mouth. 1 yr or >, must referred to a dentist annually)

Dental Home: _____ (Assess whether the child has a dental home. If non, refer to a dental home)

Documentation of Fluoride Supplementation: ☐ Yes ☐ No ☐ Refused **Date:** _____

Documentation of Fluoride Varnish: ☐ Yes ☐ No ☐ Refused **Date:** _____

(once teeth are present for children 5 years and younger every 3-6 months in primary care or dental office. If at dental office, there must specific notation that fluoride varnish was applied)

Depression Screening: _____ **Maternal Depression Screening:** _____ (1-,2-,4- and 6- month visits)
Dyslipidemia Screening: _____ (order 1 Lipid Panel between 9 and 11 and again at 17 and 21 years)
Hepatitis B Screening: _____
HIV Screening Date: (starting at age 13. Once between 15 and 18 years): _____
Intimate Partner Violence Screening: _____
Psychosocial/Behavioral Assessment: _____ (at every Well child visit)
Sexual Activity Assessment: _____ (starting at 11 yrs.) **If sexually active:**
Documentation of contraceptive care: ☐ Yes ☐ No ☐ Refused **Date:** _____
STI screening: ☐ Yes ☐ No ☐ Refused **Date:** _____

Folic Acid Supplementation (all women who are planning or capable of pregnancy. Can documentation of Folic Acid counseling and/or patient refusal) _____
Skin Cancer Behavior Counseling: _____ (6 months to 24 years)

Tobacco Products Use: Screening & Prevention Cessation services: (11 yrs or older) **Date:** _____
If yes: Prevention documented? ☐ Yes ☐ No ☐ Refused
Cessation Services provided? ☐ Yes ☐ No ☐ Refused

Immunizations: ☐ Updated ☐ No (must be up-to-date for age per CDC unless contraindicated or parent refuses)
Documentation must include: manufacturer, lot #, site, administrator's signature or initials) VIS documentation: document publication date of each vaccine, if administered