PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

# BRIGHT FUTURES PREVISIT QUESTIONNAIRE
# 2 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. **Autism Spectrum Disorder screening is also part of this visit.** Thank you.

## WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

## TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

## YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

**Check off each of the tasks that your child is able to do.**

- ☐ Play with other children and express interest in their play.
- ☐ Take off some clothing.
- ☐ Scoop well with a spoon.
- ☐ Use 50 words.
- ☐ Combine 2 words into a short phrase or sentence.
- ☐ Follow a 2-step command (such as "Pick it up and put it away").
- ☐ Name at least 5 body parts.
- ☐ Speak so strangers can understand 50% of what he says.
- ☐ Kick a ball.
- ☐ Jump off the ground with 2 feet.
- ☐ Run with coordination.
- ☐ Climb up a ladder at a playground.
- ☐ Stack objects.
- ☐ Turn book pages.
- ☐ Use his hands to turn objects.
- ☐ Draw lines.

PATIENT NAME: _____ DATE: _____

Please print.

# 2 YEAR VISIT

## RISK ASSESSMENT

| | | | | |
|---|---|---|---|---|
| **Anemia** | Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans? | O Yes | O No | O Unsure |
| | Do you ever struggle to put food on the table? | O No | O Yes | O Unsure |
| **Dyslipidemia** | Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)? | O No | O Yes | O Unsure |
| | Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication? | O No | O Yes | O Unsure |
| **Hearing** | Do you have concerns about how your child hears? | O No | O Yes | O Unsure |
| | Do you have concerns about how your child speaks? | O No | O Yes | O Unsure |
| **Lead** | Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months? | O No | O Yes | O Unsure |
| **Oral health** | Does your child have a dentist? | O Yes | O No | O Unsure |
| | Does your child's primary water source contain fluoride? | O Yes | O No | O Unsure |
| **Tuberculosis** | Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)? | O No | O Yes | O Unsure |
| | Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result? | O No | O Yes | O Unsure |
| | Is your child infected with HIV? | O No | O Yes | O Unsure |
| **Vision** | Do you have concerns about how your child sees? | O No | O Yes | O Unsure |
| | Do your child's eyes appear unusual or seem to cross? | O No | O Yes | O Unsure |
| | Do your child's eyelids droop or does one eyelid tend to close? | O No | O Yes | O Unsure |
| | Have your child's eyes ever been injured? | O No | O Yes | O Unsure |

## ANTICIPATORY GUIDANCE

### How are things going for you, your child, and your family?

### YOUR FAMILY'S HEALTH AND WELL-BEING

| | | |
|---|---|---|
| **Intimate Partner Violence** | | |
| Do you always feel safe in your home? | O Yes | O No |
| Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child? | O No | O Yes |
| **Living Situation and Food Security** | | |
| Is permanent housing a worry for you? | O No | O Yes |
| Do you have the things you need to take care of your child? | O Yes | O No |
| Does your home have enough heat, hot water, electricity, and working appliances? | O Yes | O No |
| Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? | O No | O Yes |
| Within the past 12 months, did the food you bought not last, and you did not have money to get more? | O No | O Yes |
| **Alcohol and Drugs** | | |
| Does anyone in your household drink beer, wine, or liquor? | O No | O Yes |
| Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? | O No | O Yes |
| **Taking Care of Yourself** | | |
| Do you take time for yourself? | O Yes | O No |
| Do you and your partner spend time alone together? | O Yes | O No |
| Do you and your family do activities together? | O Yes | O No |
| Do you have someone you can turn to if you need to talk about problems? | O Yes | O No |

PATIENT NAME: _____ DATE: _____

Please print.

# 2 YEAR VISIT

## YOUR CHILD'S BEHAVIOR

| | | |
|---|---|---|
| Is your child learning new things? | O Yes | O No |
| Do you spend time alone with your child doing something that he likes to do? | O Yes | O No |
| Do you encourage other family members and caregivers to be consistent, patient, and calm with your child? | O Yes | O No |
| Do you show your child how to be physically active every day by playing and being active with her? | O Yes | O No |
| Does your child play with other children? | O Yes | O No |
| How much time every day does your child spend watching TV or using computers, tablets, or smartphones? | _____ hours | |

## TALKING AND YOUR CHILD

| | | |
|---|---|---|
| Does your child have ways to tell you what he wants? | O Yes | O No |
| Do you use simple words when asking your child a question or telling her what to do? | O Yes | O No |
| Do you give your child plenty of time to respond? | O Yes | O No |
| Do you sing songs and talk with your child about the things you do together? | O Yes | O No |
| Do you read to your child or look at books together every day? | O Yes | O No |

## TOILET TRAINING

| | | |
|---|---|---|
| Is your child interested in using the toilet? | O Yes | O No |
| Does your child tell you when he has a bowel movement? | O Yes | O No |
| Is your child dry for about 2 hours at a time? | O Yes | O No |
| Does your child know the difference between being wet and dry? | O Yes | O No |
| Do you help your child wash her hands after going to the bathroom? | O Yes | O No |

## SAFETY

| | | |
|---|---|---|
| **Car Safety** | | |
| Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle? | O Yes | O No |
| Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat? | O Yes | O No |
| **Outdoor Safety** | | |
| Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle? | O Yes | O No |
| Do you keep your child away from moving machines, lawn mowers, driveways, and streets? | O Yes | O No |
| Do you live near any backyard swimming pools, hot tubs, or spas? | O No | O Yes |
| **Gun Safety** | | |
| Does anyone in your home or the homes where your child spends time have a gun? | O No | O Yes |
| If yes, is the gun unloaded and locked up? | O Yes | O No |
| If yes, is the ammunition stored and locked up separately from the gun? | O Yes | O No |

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

**Southern Pediatric Clinic, LLC**
**Charlene C. Blache, M.D.**
**Kereese Gayle-Farias, M.D.**
*Pediatrics and Adolescent Medicine*

406-M Northside Drive
Valdosta, GA 31602
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# Patient Information Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex M / F

Address _____ Zip Code _____ Social Security # _____

Name & birthdates of child's brothers and/or sisters (include last name if different)

Has your child ever been seen at our practice? ☐ NO ☐ YES When? _____

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ YES ☐ NO

If yes, which brothers or sisters? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's previous doctor _____

Name of parents' family doctor _____

Name of mother's obstetrician/gynecologist _____

How did you hear about SPC?
□Physician / Hospital □Marketing Ads □ Social Media (Facebook / Instagram)
□ Google □ SPC's Website □ Patient □ Signage (building)
□ Related Profession (Physical Therapy etc.):_____
□ Other: _____

**MOTHER'S NAME WHO IS LEGAL GUARDIAN** _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

**FATHER'S NAME WHO IS LEGAL GUARDIAN** _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

**MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD**

| Primary Policy Holder Name | Primary Insurance | Secondary Ins./Medicaid |
|---|---|---|

**EMERGENCY CONTACT OTHER THAN PARENT** Name _____

Relationship _____ Address _____ Home Phone _____

I authorize **Dr. Blache** to release any medical information necessary to process an insurance claim for my son/daughter _____ and request the insurance company to make payment to **Dr. Blache**. I also authorize **Southern Pediatric Clinic, LLC staff and/or Dr. Blache** to use the contact information listed above.

| Parent/Guardian Printed Name | Signature | Date |
|---|---|---|

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# Financial Consent

1. ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:

____ Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name _____ Date of Birth _____

Responsible Party Name and Signature _____ Today's Date _____

**MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)**

| Primary Policy Holder Name | Primary Insurance | Primary Insurance Policy Number |
|---|---|---|
| M F | | |
| Primary Policy Sex / Date of Birth | Secondary Ins./Medicaid | Secondary Ins./Medicaid Policy Number |

_____
Office Staff Initials

**Southern Pediatric Clinic, LLC**
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## Consent & Disclosure of PHI & Treatment of Patient & Statement of Persons Allowed to Accompany Patient to Office Visits

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

**MOTHER'S NAME WHO IS LEGAL GUARDIAN** _____ Birthdate _____

**FATHER'S NAME WHO IS LEGAL GUARDIAN** _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

**DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.**

| Name | Relationship to Patient | Disclose PHI | Accompany to Appointment |
|---|---|---|---|
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |
| | | □ yes □ no | □ yes □ no |

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I my revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

_____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

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Child's Name _____ DOB _____

## CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone ("cellphones") and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as "communication devices") at *Southern Pediatric Clinic, LLC.* These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC,* along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**
   This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**
   a. All devices that can be used for recording.
   b. All devices that can be used for communicating with others.
   c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**
   The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**
   Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

_____

Signature of Parent/Guardian or Patient Date

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Child's Name _____ Date of Birth _____ Today's Date _____

# M-CHAT Autism Screen

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (i.e., you've seen it once or twice), please answer as if the child does ***not*** do it.

| Questions | Yes | No |
|---|---|---|
| 1. Does your child enjoy being swung, bounced on your knee, etc.? | ☐ | ☐ |
| 2. * Does your child take an interest in other children? | ☐ | ☐ |
| 3. Does your child like climbing on things, such as up stairs? | ☐ | ☐ |
| 4. Does your child enjoy playing peek-a-boo/hide-and-seek? | ☐ | ☐ |
| 5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things? | ☐ | ☐ |
| 6. Does your child ever use his/her index finger to point, to ask for something? | ☐ | ☐ |
| 7. * Does your child every use his/her index finger to point, to indicate interest in something? | ☐ | ☐ |
| 8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them? | ☐ | ☐ |
| 9. * Does your child ever bring objects over to you (parent) to show you something? | ☐ | ☐ |
| 10. Does your child look you in the eye for more than a second or two? | ☐ | ☐ |
| 11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) | ☐ | ☐ |
| 12. Does your child smile in response to your face or your smile? | ☐ | ☐ |
| 13. * Does your child imitate you? (e.g., if you make a face, will your child imitate it?) | ☐ | ☐ |
| 14. * Does your child respond to his/her name when you call? | ☐ | ☐ |
| 15. * If you point at a toy across the room, does your child look at it? | ☐ | ☐ |
| 16. Does your child walk? | ☐ | ☐ |
| 17. Does your child look at things you are looking at? | ☐ | ☐ |
| 18. Does your child make unusual finger movements near his/her face? | ☐ | ☐ |
| 19. Does your child try to attract your attention to his/her own activity? | ☐ | ☐ |
| 20. Have you ever wondered if your child is deaf? | ☐ | ☐ |
| 21. Does your child understand what people say? | ☐ | ☐ |
| 22. Does your child sometimes stare at nothing or wander with no purpose? | ☐ | ☐ |
| 23. Does your child look at your face to check your reaction when faced with something unfamiliar? | ☐ | ☐ |

***Two or more of the asterisked (*) items, or three of any items require more evaluation or referral.***

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**PATIENT**

| Last Name | First Name | MI | Date of Birth |
|---|---|---|---|

**PARENT/GUARDIAN**

| Last Name | First Name | MI |
|---|---|---|

# Patient Eligibility Screening Record

## Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

| **Check only ONE (1) box. My child…** | | |
|---|---|---|
| (A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid). | ◯ | OR |
| (B) is American Indian or Alaskan Native. | ◯ | OR |
| (C) does not have health insurance. | ◯ | OR |
| (D) has health insurance that does not pay for vaccines. | ◯ | OR |
| (E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider). | ◯ | OR |
| (F) has health insurance that pays for vaccines. | ◯ | |

.

Parent/Guardian Name (print) Signature Date

# PEDS Response Form

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

1. Please list any concerns about your child's learning, development, and behaviour.

2. Do you have any concerns about how your child talks and makes speech sounds?

*Circle one:* No Yes A little COMMENTS:

3. Do you have any concerns about how your child understands what you say?

*Circle one:* No Yes A little COMMENTS:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

*Circle one:* No Yes A little COMMENTS:

5. Do you have any concerns about how your child uses his or her arms and legs?

*Circle one:* No Yes A little COMMENTS:

6. Do you have any concerns about how your child behaves?

*Circle one:* No Yes A little COMMENTS:

7. Do you have any concerns about how your child gets along with others?

*Circle one:* No Yes A little COMMENTS:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

*Circle one:* No Yes A little COMMENTS:

9. Do you have any concerns about how your child is learning preschool or school skills?

*Circle one:* No Yes A little COMMENTS:

10. Please list any other concerns.

# PEDS Score Form – Authorised Australian Version

Child's Name:_____ Date of Birth:_____ Date(s) of scoring:_____

Find appropriate column for the child's age. Place a tick in the appropriate box to show each concern on the PEDS Response Form. See Brief Scoring Guide for details on categorising concerns. Shaded boxes are significant predictors of difficulties. Non-shaded boxes are non significant predictors.

| Child's Age: | 0-3 mos | 4-5 mos | 6-11 mos | 12-14 mos | 15-17 mos | 18-23 mos | 24-35 mos | 36-47 mos | 48-53 mos | 54-71 mos | 72-83 mos | 84-96 mos |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Global/Cognitive | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Expressive Language and Articulation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Receptive Language | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Fine Motor | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gross Motor | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Behaviour | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Social-emotional | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Self-help | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| School | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Count the number of ticks in the small shaded boxes and place the total in the large shaded box below.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

If the number shown in the large shaded box is 2 or more, follow **Path A** on PEDS Interpretation Form. If the number shown is exactly 1, follow **Path B**. If the number shown is 0, count the number of ticks in the small unshaded boxes and place the total in the large unshaded box below.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

If the number shown in the large unshaded box is 1 or more, follow **Path C**. If the number 0 is shown, consider **Path D** if relevant. Otherwise, follow **Path E**.



Child's Name:_____ Date of Birth:_____

# PEDS Interpretation Form

**Path A:** Two or more significant predictive concerns? → Yes? → Two or more concerns about self-help, social, school, or receptive language skills?
- Yes? → Refer for audiological and speech-language testing. Use professional judgment to decide if referrals are also needed for social work, occupational/physiotherapy, mental health services, etc.
- No? → Refer for intellectual and educational assessments. Use professional judgment to decide if speech-language, audiological, or other evaluations are also needed.

**Path B:** One significant predictive concern? → Yes? → Screen or refer for screening.
- If screen is passed, counsel in areas of concern and monitor carefully.
- If screen is failed, refer for testing in area(s) of difficulty.

**Path C:** Non significant concerns? → Yes? → Counsel in areas of difficulty and follow up in several weeks. → If unsuccessful, screen for emotional/behavioural problems and refer as indicated. Otherwise refer for parent training, behavioural intervention, etc.

**Path D:** Parental difficulties communicating? → Yes? → Foreign language a barrier?
- No? → Use a second screen that directly elicits children's skills or refer for screening elsewhere.
- Yes? → Send PEDS home in preparation for a second visit; seek an interpreter, or refer for screening elsewhere.

**Path E:** No concerns? → Yes? → Elicit any concerns at future time-point? → Use PEDS at future time-point.



## Specific Decisions

0–3 mos. _____

4–5 mos. _____

6–11 mos. _____

12–14 mos. _____

15–17 mos. _____

18–23 mos. _____

24–35 mos. _____

36–47 mos. _____

48–53 mos. _____

54–71 mos. _____

72–83 mos. _____

84–96 mos. _____

PROVIDER ONLY