Flanders Pediatrics, LLC

Maria A.Lopez, MD, FAAP
Amy Blodgett, MD, FAAP
Zachary Kahn, DO, FAAP
Elizabeth Henry, APRN
Katie Grigg, APRN
Stephanie Adams, APRN

The American Academy of pediatrics (AAP) has developed a set of comprehensive health guidelines for well-child visits to help Pediatricians to diagnose other medical conditions that may otherwise be missed during these visits. Each well-child visit has an age-appropriate pre-visit questionnaire. You will notice the questions focus on the developmental milestones, nutrition, safety, your child and family's emotional well-being and other recommendations from the AAP.

Examples of the various questions you may see at each well-child visit are as follows:

*Ages and Stages developmental screening questionnaires at 9,12,18,24,30,36,48 & 60 month visit
*Postpartum depression screening (for mothers) during the 2 Month well child visit
*Autism screening at 18 months and 24 months of age (in the future 4 year old will be screened as well)
*Alcohol and drug screening
*Adolescent screening which includes the following:
PSC-17(Pediatric Symptom checklist) for ages 4-17 years
PHQ-9 (Patient Health Questionnaire) Depression Screening for ages 13 and older

In addition to the above screenings, additional behavioral health screenings may be conducted where the need arises, they are as follows:
Vanderbilt Questionnaires (ADHD/ADD)
GAD-7 (Generalized Anxiety Disorder) for anxiety and patient risk
SCARED (Screen for Child Anxiety related Emotional Disorders) for ages 8 & older
CRAFFT for substance abuse screening

Please be aware that this is a billable and acceptable charge to your insurance company.

Although these screenings tools are recommended to provide comprehensive care to you child some insurance companies may not pay for these services and/or may apply them towards your deductible. Please understand that it is unknown to us which health plans will or will not cover these questionnaires, you may receive a statement for these services if your insurance denies the claim(s).

Patients Name _____ **Date of Birth** _____

Parent Name _____ **Parent Signature & Date** _____

I _____ **wish to decline filling out the questionnaires**.

Signature & Date_____

305 Flanders Road PO Box 278
East Lyme, CT 06333
Phone: (860) 739-0348 Fax: (860) 739-6779
www.flanderspediatrics.com

Rev. 02/2025