PEDIATRIC HEALTHCARE ASSOCIATES
(203) 452-8322

Dear Caregiver / Patient,

Today you are being asked to complete one or more of the following developmental and/or emotional tests. The appropriate tests, based on your child's age, are included in this packet.

- ☐ **ASQ Screening** – for all children 9 months to 15 months of age (this will be given in the office)
- ☐ **MCHAT Test** – done at 18 months and 24 months
- ☐ **Pediatric Symptom Checklist (PSC-17)** – for all children 6 to 15 years of age
- ☐ **Modified Testing for Teens (PHQ-9)** – for all teens 16 & 17 years of age
- ☐ **Patient Health Questionnaire (PHQ-9)** – 18 years and older
- ☐ **Edinburgh Postnatal Depression Scale (EPDS)**
- ☐ **Social Determinants of Health (SDoH)** – all annual well exams
- ☐ **Preschool Pediatric Symptom Checklist (PPSC)** – 30 months to 5 years of age
- ☐ **Tuberculosis Screening**

All of these standardized tests are recommended by the American Academy of Pediatrics to determine any signs of developmental and/or emotional concerns.

These tests will be submitted to your insurance company. Depending on your plan, the testing might be subject to a deductible or co-insurance.

<u>If so, you will be billed for any patient balance.</u>

Child's Name _____ Filled Out By _____

Date of Birth _____ Relationship to Child _____ Today's Date _____

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No

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Total Score _____

Tuberculosis Risk-Assessment Questionnaire

1. Was this child born in a country other than the United States? YES NO

   If yes, where was he/she born and when did they come to the U.S.?

   _____

2. Was this child's mother or father born in a country other than the United States? YES NO

   If yes, where were they born and when did they come to the U.S.?

   _____

3. Has this child traveled to another country since their last physical exam? YES NO

   If yes, where did he/she travel? _____

   With whom did he/she stay? Friends / Relatives Hotel

   Were they there for one month or more? YES NO

4. Has this child been exposed to anyone with tuberculosis or a positive TB skin test since his/her last physical exam? YES NO

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(203) 452-8322
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Fairfield, CT 06824

Shelton
4 Corporate Dr. - 290
Shelton, CT 06484

Stratford
99 Hawley Lane
Stratford, CT 06614

Trumbull
15 Corporate Dr.
Trumbull, CT 06611

Shelton
Business Office
100 Beard Sawmill Rd. - 430
Shelton, CT 06484

SDoH Screening Tool

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

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