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>

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

Edinburgh Postnatal Depression Scale (EPDS)

Date:_____ **Patient Name:** _____ **DOB:** _____

Mother's Name: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **Check Mark (✓)** on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS** – not just how you feel today. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test, not a medical diagnosis. If something doesn't seem right, please call your health care provider regardless of your score.

Below is an example already completed.

I have felt happy:

Yes, all of the time	___(0)
Yes, most of the time	✓ (1)
No, not very often	___(2)
No, not at all	___(3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the questions below in the same way.

1. I have been able to laugh and see the funny side of things:

As much as I always could	___(0)
Not quite so much now	___(1)
Definitely not so much now	___(2)
Not at all	___(3)

2. I have looked forward with enjoyment to things:

As much a I ever did	___(0)
Rather less than I used to	___(1)
Definitely less than I used to	___(2)
Hardly at all	___(3)

3. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time	___(3)
Yes, some of the time	___(2)
Not very often	___(1)
No, never	___(0)

4. I have been anxious or worried for no good reason:

No, not at all	___(0)
Hardly ever	___(1)
Yes, sometimes	___(2)
Yes, very often	___(3)

5. I have felt scared or panicky for no good reason:

Yes, quite a lot	___(3)
Yes, sometimes	___(2)
No, not much	___(1)
No, not at all	___(0)

6. Things have been getting to me:

Yes, most of the time I haven't been able to cope at all	___(3)
Yes, sometimes I haven't been coping as well as usual	___(2)
No, most of the time I have coped quite well	___(1)
No, I have been coping as well as ever	___(0)

7. I have been so unhappy that I have had difficulty sleeping:

Yes, most of the time	___(3)
Yes, sometimes	___(2)
No, not very often	___(1)
No, not at all	___(0)

8. I have felt sad or miserable:

Yes, most of the time	___(3)
Yes, quite often	___(2)
Not very often	___(1)
No, not at all	___(0)

9. I have been so unhappy that I have been crying:

Yes, most of the time	___(3)
Yes, quite often	___(2)
Only occasionally	___(1)
No, never	___(0)

10. The thought of harming myself has occurred to me:

Yes, quite often	___(3)
Sometimes	___(2)
Hardly ever	___(1)
Never	___(0)

To Be Completed by PHA Office

TOTAL SCORE HERE ▷ ____

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.