

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

Child's Name:_____ Date of Birth: _____

Filled Out By: _____ Today's Date: _____

Pediatric Symptom Checklist 17 (PSC-17)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:	Never	Sometimes	Often
◆ Fidgety, unable to sit still	0	1	2
■ Feels sad, unhappy	0	1	2
◆ Daydreams too much	0	1	2
● Refuses to share	0	1	2
● Does not understand other people's feelings	0	1	2
■ Feels hopeless	0	1	2
◆ Has trouble concentrating	0	1	2
● Fights with other children	0	1	2
■ Is down on him or her self	0	1	2
● Blames others for his or her troubles	0	1	2
■ Seems to have less fun	0	1	2
● Does not listen to rules	0	1	2
◆ Acts as if driven by a motor	0	1	2
● Teases others	0	1	2
■ Worries a lot	0	1	2
● Takes things that do not belong to him or her	0	1	2
◆ Distracted easily	0	1	2

OFFICE USE ONLY

Total ◆_____ Total ●_____ Total ■_____ ◆ + ● + ■_____

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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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