**Early Head Start, Head Start & Family Support Center**

**Chart Review Checklist**

|  |
| --- |
| Name of Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_  Current Age of Child in Months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Age at Enrollment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Care Provider’s Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List all of child’s chronic health conditions. If none, check here:  Asthma Severe Allergy/Anaphylaxis (List allergens) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seizures Failure to Thrive Other (List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Well Child Check-Up (0 – 36 months)**  **(Per EPSDT Schedule)**  Date of Most Recent Well Child Check: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at this check-up (months) \_\_\_\_\_\_\_\_  Current Behind (Please circle one)  If child is behind, when was the last well child check-up due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Month Year |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Immunizations**  Are Immunizations up-to-date? Yes No  If immunizations are not up-to-date, which immunizations are past due? Please circle the box of the immunization due.   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Dose # | DTaP | Polio | Hib | Hep B | PCV | RV | Hep A | MMR | Varicella | | 1 | 2 mos. | 2 mos. | 2 mos. | Birth | 2 mos. | 2 mos. | 12-23 mos. | 12-15 mos. | 12-15 mos. | | 2 | 4 mos. | 4 mos. | 4 mos. | 1-2 mos. | 4 mos. | 4 mos. | 6-18 mos. after dose 1 | 4-6 yrs. | 4-6 yrs. | | 3 | 6 mos. | 6-18 mos. | 6 mos. | 6-18 mos. | 6 mos. | 6 mos. |  |  |  | | 4 | 15-18 mos. |  | 12-15 mos. |  | 12-15 mos. |  |  |  |  |   *Note: Immunizations listed are recommended for children from birth through 6 years old.*  **Laboratory Tests**  *Note: If child is < 12 months of age, lead and anemia tests not needed.*  **Blood Lead:**  Please indicate by checking the box below if the test was performed and the result of the test.  12 months: Yes No N/A Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  24 months: Yes No N/A Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If BLL ³ 5 ug/dL, is there documentation that the child is receiving follow-up care? Yes No  **Anemia (Hgb/Hct):**  12 months: Yes No N/A Result: Normal Abnormal  24 months: Yes No N/A Result: Normal Abnormal  If result is abnormal, is there documentation that the child is receiving follow-up care? Yes No    **\*DNP Exam Recommended Yes No** |