**Early Head Start, Head Start, and Family Support Centers**

**Chart Review Checklist**

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| Name of Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewer’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of EHS Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Age of Child in Months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Age at Enrollment Date:\_\_\_\_\_\_\_\_\_  Provider’s Name and Contact Information:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List all of child’s chronic health conditions. If none, check here:  Asthma Severe Allergy/Anaphylaxis (List allergens) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Seizures Failure to Thrive Other (List) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the child have a care plan for each identified health condition? Yes No |

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| **Child’s DOB: \_\_\_\_\_\_\_\_\_\_ Child’s Current Age (mos.): \_\_\_\_\_\_\_\_\_\_**  **Well Child Check-Up (0 – 36 months)**  Date of Most Recent Health Inventory: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at this check-up (months) \_\_\_\_\_\_\_\_  Compliant Not compliant (Please circle one)  If not compliant, when was the last well child check-up due? (Provide month and year)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (If noncompliant, place colored dot on upper right side of binder cover.)  Month Year  When is the next well child check-up due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Month Year  Please provide date when last assessment was done for the following:  Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nutrition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hearing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oral/Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Measurements/Graphing:  Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Child’s DOB: \_\_\_\_\_\_\_\_\_\_ Child’s Current Age (mos.): \_\_\_\_\_\_\_\_\_\_**  **Laboratory Tests**  *Note: If child is < 12 months of age, lead test 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 Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s age (mos.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If BLL ³ 5 ug/dL, is there documentation that the child is receiving follow-up care? Yes No  24 months: Yes No Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s age (mos.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If BLL ³ 5 ug/dL, is there documentation that the child is receiving follow-up care? Yes No  If test was due but has not been performed, please provide month/year when test was due: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Month Year |

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| **Child’s DOB: \_\_\_\_\_\_\_\_\_\_ Child’s Current Age (mos.): \_\_\_\_\_\_\_\_\_\_**  **Laboratory Tests**  *Note: If child is < 12 months of age, anemia test not needed.*  **Anemia (Hgb/Hct):**  Please indicate by checking the box below if the test was performed and the result of the test.  12 months: Yes No Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s age (mos.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Result: Normal Abnormal  If result is abnormal, is there documentation that the child is receiving follow-up care?  Yes No  24 months: Yes No Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s age (mos.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Result: Normal Abnormal  If result is abnormal, is there documentation that the child is receiving follow-up care?  Yes No  If test was due but has not been performed, please provide month/year when test was due: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Month Year |

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| **Child’s DOB: \_\_\_\_\_\_\_\_\_\_ Child’s Current Age (mos.): \_\_\_\_\_\_\_\_\_\_**  **Immunizations**  Is Form 896 in child’s record? Yes No 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.* |

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| **Preventive Screen Questionnaire:**  Please provide the date when the last risk assessment was done and check the box yes or no if the assessment is current.   1. Lead (every well child visit from 6 months to 6 years): \_\_\_\_\_\_\_\_\_\_ Current? Yes No 2. Tuberculosis (starting at 1 month and annually thereafter): \_\_\_\_\_\_\_\_\_\_   Current? Yes No   1. Heart Disease/Cholesterol (2 years through 20 years): \_\_\_\_\_\_\_\_\_\_ Current? Yes No   *Note: Sometimes these assessments are included as part of a provider’s notes that are included in the chart. Please read through the entire health section of the child’s record to determine if the assessments have been done before marking these items as not performed.* | |
| **Child’s DOB: \_\_\_\_\_\_\_\_\_\_ Child’s Current Age (mos.): \_\_\_\_\_\_\_\_\_\_**  **Health Education (counseling/referrals provided):**  Please check yes or no for the following information.   1. Were any growth/development problems identified? Yes No    1. If yes, was discussion with the parent documented? Yes No    2. Was a referral made? Yes No    3. Was counseling provided? Yes No 2. For a child 12 months and older, is a dentist identified? Yes No    1. Has the child been referred to a dentist? Yes No 3. Is a return visit scheduled for the next well child exam or follow-up appointment? Yes No    1. Does the date of the next scheduled visit meet the Healthy Kids requirements   for well child visits? Yes No | |