

If no label:

Name _____

Birth Date _____

Date of Encounter _____

C&TC/Well-Child Exam

15 Month Visit

= C&TC
Mandatory
Components

This is a C&TC:
Yes No

Ht. _____ Primary MD _____

Wt. _____ Allergies _____

Head Circumference _____ Medications _____

Temperature _____

Recent injury/illness/surgery/hospitalization _____

Staff Signature _____

Health History

Parent concerns:

Family Social History/Medical History:

Caregivers:

Who brought baby in? _____

Who lives with baby? _____

Caregiver working/in school? Yes No

Who cares for baby during work/school day?

Parent/Relative Day Care

Stresses for caregivers _____

Environment: *Check areas discussed*

Housing Drug use Alcohol

Domestic Violence Guns

Exposure to secondhand smoke TB exposure

Lead risk Other risks _____

No environmental problems identified

Nutrition: *Check those that apply*

Breast frequency _____

Whole milk amount _____ Juice (oz/day) _____

Solids Iron Vitamins Fluoride

Sleep: Arrangements/patterns _____

Hygiene: Bathing frequency _____

Dental: Brushing _____

Anticipatory Guidance *Circle areas discussed*

Nutrition: Balanced diet/nutritious snacks; no bottles; iron, calcium sources; avoid food conflict; family meals; choking prevention-no popcorn, nuts, gum, raisins, etc.

Safety: Car seat; smoke detectors; window guards; poisonous plants; lock up cleaning products and medications; Ipecac/poison control number; never leave unattended, esp. in water, near stove, fan, machinery, in car; socket plugs; plastic bags, balloons, sharps, toys with small parts; no walkers; stairway gates; sun protection; hot water temp <125°; no smoking around baby; rescue of choking baby; eliminate lead risks.

Parenting: Talk, sing, play with baby; autonomy/dependency needs; consistent scheduling; tantrums; hitting, biting, aggressive behavior; never punish, jerk or shake; model healthy habits; media violence; safe child care; discuss use of OTC meds; teeth brushing; minor illness care; infection risk reduction.

Pamphlet/Information Sheet Given 99401 - 15min
Requires additional Health Education 99402 - 30min

Mental Health

No Concerns Concerns Explain: _____

Development *Give developmental screening results or complete chart.*

Screening Tool (name) _____

Normal Abnormal

Age _____

Denver Developmental Screening Test II or equivalent 96110

by Hx observed

Drinks from cup

Waves bye-bye

	by Hx	observed
Imitates activities		
Begins scribbling		
Can put object into cup		
Has two words		
Dada/Mama specific		
Walks well		
Stoops and recovers		
Stands alone		
Walks backwards		

Physical Exam (✓) N=normal A=abnormal

	N	A
General appearance		
Skin: color • character • birthmarks		
Nodes: cervical • axillary • inguinal		
Head: shape • AF size • scalp • hair		
Eyes: red reflex • corneal light reflex • strabismus PERL • EOM • lids		
Vision: follows objects		
Ears: pinna • canals • TMs		
Hearing: localization of sound		
Nose: patency • nares		
Mouth: gums • mucosa • throat • teeth		
Neck: position • ROM • thyroid		
Chest: shape • symmetry • lungs • respiration rate		
CV: rate • rhythm • S 1 • S 2 • murmur • femoral pulses		
Abd: liver • spleen • masses • bowel sounds • anus		
GU: ♀ labia • vaginal mucosa ♂ penis • testes • hydrocele • hernia		
MS: ROM • hips • spine		
Neuro: posture • DTRs • tone • Babinski • Clonus		

Physical Exam
(Health History included)

Billing Codes: 99381-99385
99391-99395 OR 99431-99432
With Dx codes V20-V20.2 and/or V70.0 and/or V70.3-V70.9
99201-99205
99211-99215

Parent-Child Interaction

No concerns Concerns (Explain) _____

Labs

Lead: 83655
Hgb: 85018

Hemoglobin (mandatory once between 9&15 months)

Other labs ordered: _____

Vision/Hearing Yes No

Vision concerns?

Hearing concerns?

Immunizations

Immunizations: Reviewed On schedule

Deferred - reason: _____

Parent refused

Previous reaction? Yes No

Given: Hepatitis B PCV DTaP IPV

Hib MMR Varicella Other _____

Has had Chicken Pox infection

MNVFC: 90471 or 90472.

List actual immunization given with an SL modifier and a \$.01 charge.

Assessment and Plan See dictation

Child and Teen Checkup Completed, child well

Other: _____

Referral _____

Encourage smoking cessation-parent

IPECAC prescription

Poison Control number

WIC enrolled, if eligible

18 month visit scheduled

MD Signature _____

C&TC Referral Codes
(Box 24H-CMS 1500):
Check One

NU	No referral was made	
ST	Referral	
S2	Patient is currently under treatment	
AV	Patient refused referral	

Physician / Nurse

Physician

Nurse

Physician