



Bright Futures Parent Handout 15 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

COMMUNICATION AND SOCIAL DEVELOPMENT

Talking and Feeling

- Show your child how to use words.
- Use words to describe your child's feelings.
- Describe your child's gestures with words.
- Use simple, clear phrases to talk to your child.
- When reading, use simple words to talk about the pictures.
- Try to give choices. Allow your child to choose between 2 good options, such as a banana or an apple, or 2 favorite books.
- Your child may be anxious around new people; this is normal. Be sure to comfort your child.

A Good Night's Sleep

- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Put your child to bed at the same time every night. Early is better.
- Try to tuck in your child when she is drowsy but still awake.
- Avoid giving enjoyable attention if your child wakes during the night. Use words to reassure and give a blanket or toy to hold for comfort.

SLEEP ROUTINES AND ISSUES

Safety

- It is best to keep your child's car safety seat rear-facing until she reaches the seat's weight or height limit for rear-facing use. Do not switch your child to a forward-facing car safety seat until she is at least 1 year old and weighs at least 20 pounds.
- Follow the owner's manual to make the needed changes when switching the car safety seat to the forward-facing position.
- Never put your child's rear-facing seat in the front seat of a vehicle with a passenger airbag. The back seat is the safest place for children to ride.
- Everyone should wear a seat belt in the car.
- Lock away poisons, medications, and lawn and cleaning supplies.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Keep your child away from pot handles, small appliances, fireplaces, and space heaters.
- Lock away cigarettes, matches, lighters, and alcohol.
- Have working smoke and carbon monoxide alarms and an escape plan.
- Set your hot water heater temperature to lower than 120°F.

SAFETY

Temper Tantrums and Discipline

- Use distraction to stop tantrums when you can.
- Limit the need to say "No!" by making your home and yard safe for play.
- Praise your child for behaving well.
- Set limits and use discipline to teach and protect your child, not punish.
- Be patient with messy eating and play. Your child is learning.
- Let your child choose between 2 good things for food, toys, drinks, or books.

TEMPER TANTRUMS AND DISCIPLINE

Healthy Teeth

- Take your child for a first dental visit if you have not done so.
- Brush your child's teeth twice each day after breakfast and before bed with a soft toothbrush and plain water.
- Wean from the bottle; give only water in the bottle.
- Brush your own teeth and avoid sharing cups and spoons with your child or cleaning a pacifier in your mouth.

HEALTHY TEETH

What to Expect at Your Child's 18 Month Visit

We will talk about

- Talking and reading with your child
- Playgroups
- Preparing your other children for a new baby
- Spending time with your family and partner
- Car and home safety
- Toilet training
- Setting limits and using time-outs

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



American Academy
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Name: _____

FMP and Sponsor Last Four: _____ / _____

Date: _____

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas.
If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

1. **No Allergies** Please list any allergies you have (drug, food, latex)

Clinic Use Only

BP	/	HT	Visual Acuity: R 20/____ L 20/____ Both 20/____
HR		WT	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____
RR		HC	
TEMP		SpO2	

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates) (Circle all that apply)	Family History—(Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
NO Medical Conditions Asthma Diabetes Hayfever/Allergies Other:	NO History of Surgeries Ear Tubes Tonsillectomy Adenoidectomy Appendectomy Circumcision Other:	Birth Defects Deafness before Age 5 Kidney Disease Post Partum Depression Early or Sudden Death to include SIDS Heart attack before age 50 High Blood Pressure High Cholesterol Hypertrophic Cardiomyopathy Long QT syndrome Arrhythmias Diabetes Mental illness Alcohol or Substance Abuse Genetic or Metabolic Disease Other:	Please list all prescribed medications including supplements, herbals and vitamins obtained over the counter. <input checked="" type="checkbox"/> Infant Multivitamin 1 ml per day

BIRTH HISTORY-Complete for AGES NEWBORN TO 2 YEARS

Place of Birth: _____
 Birth weight? _____ # weeks pregnant at delivery? _____
 Prenatal complications No Yes describe: _____
 Group B Strep. (GBS) Positive Negative Don't Know
 Type of Delivery (check all that apply):
 Vaginal Forceps Vacuum-assisted C-section Breech
 Complications at birth?
 Jaundice * Yes No Phototherapy * Yes No Hip Click/Clunk * Yes No
 Other: _____
 Did your child receive the Hepatitis B vaccine at birth? Yes No Unsure

Newborn Metabolic Screen Submitted:

Yes No Don't Know
 Repeated
Baby's Hearing Screen:
 Passed Bilateral
 Repeat Needed
 Don't Know

Clinic Use Only - For Newborns-2 weeks
Complete Risk assessment for Jaundice (Bill and Blood Type)

Source of Medical Information: Mother Father Patient Other

Any hospitalizations, specialty care, or ER visits since your last appointment? No Yes

Would you say your child's Overall Feeling of health is? Excellent Very Good Good Fair Poor

Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? Yes No Decline

Are your child's immunizations up to date? Yes Unsure No

Does your child have a chronic medical or behavioral health problem, and/or physical disability? No Yes

Is frequent follow-up support required for the above issues? No Yes

Does your child require early interventions or special education services? No Yes

Is your child enrolled in the Exceptional Family Member Program? No Yes

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Is your child In Day-Care
 Does anyone in the family smoke or is your child exposed to secondhand smoke? No Yes
 Who does the child live with? Parents Mother Father Other _____
 Is Sponsor currently deployed? No Yes
 Is this visit deployment related? No Yes
 Does your child ride in a car with a car-seat? Yes No

Tuberculosis Screening - Complete at 1, 6, 12, and 18 month Well Child Visit
 Yes No Unsure Has a family member or contact had tuberculosis?
 Yes No Unsure Has a family member had a positive tuberculin skin test?
 Yes No Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, or Western Europe)?
 Yes No Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

Lead Screening - Complete at 6, 9, 12, and 18 Month Well Child Visit
 Yes No Unsure Does your child have a sibling or playmate with Hx of lead poisoning?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1950?
 Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

What is your preferred method for learning: Verbal Written Visual Hands-On Other: _____
 Yes No - Do you or your child have learning/readiness needs?
 Yes No - Are there cultural or religious considerations that affect your child's healthcare?
 Yes No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?
****PLEASE PROVIDE A GOOD CONTACT NUMBER: _____**

Breastfeeding? Yes No How often? _____ Minutes per breast? _____ Concerns? _____
 Bottle feeding? Yes No Brand? _____ Ounces per feed? _____ How often? _____
 Number of wet diapers per day? _____ Stools per day? _____
 Circle if you have any concerns about the following (circle all that apply): Bowel movements / Constipation / Sleep problems

If Edinburgh Postpartum Depression Screen (EPDS) not attached.
 Mother please complete below questionnaire at 1week, 2 and 4 month Well Child visits.

Over the last 2 weeks, how often have you been bothered by any of the following?
 Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day
 Feeling depressed or hopeless? Not at all Several days More than half the days Nearly every day

------(This section NOT for patient use)-----

Treatments/orders for this visit - Ensure Patients Name and last four on Front of Document

<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Ear Irrigation	<input type="checkbox"/> CBC	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Bilirubin (T/D)	<input type="checkbox"/> CXR
<input type="checkbox"/> RSV Swab	Left _____ Right _____	<input type="checkbox"/> UA	<input type="checkbox"/> HbA1c	<input type="checkbox"/> TsBill	<input type="checkbox"/> EKG
<input type="checkbox"/> Strep Screen/ITEx	<input type="checkbox"/> Saline Bulb Suction	<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> TSH/T4	<input type="checkbox"/> Monospot	
<input type="checkbox"/> Tussin Swab	<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> BMP	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Dex	<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> CMP	<input type="checkbox"/> Lead		
<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE	<input type="checkbox"/> PPD	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Immunizations - 2 Month - Pediarix (DTaP-IPV-HepB), Hib, PCV-13, Rotateq					

Well Child Developmental Screenings

1 Week (3-5 days)	1 MONTH	2 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Eats well	<input type="checkbox"/> If upset, able to calm	<input type="checkbox"/> Lifts head and begins to push up when prone
<input type="checkbox"/> Follows your face	<input type="checkbox"/> Has started to smile	<input type="checkbox"/> Holds head erect for short period (when held upright)
<input type="checkbox"/> Turns and calms to your voice	<input type="checkbox"/> Recognizes voice of parents	<input type="checkbox"/> Diminished newborn reflexes
<input type="checkbox"/> Can suck, swallow and breath easy	<input type="checkbox"/> Follows parents with eyes	<input type="checkbox"/> Symmetrical movements
	<input type="checkbox"/> Able to lift head when on tummy	<input type="checkbox"/> Indicates boredom when no activity change
		<input type="checkbox"/> Coos
		<input type="checkbox"/> Different crying for different needs
		<input type="checkbox"/> Smiles
		<input type="checkbox"/> Looks for parents
		<input type="checkbox"/> Self-comfort
4 MONTH	6 MONTH	9 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Pushes chest to elbows	<input type="checkbox"/> Sits briefly leaning forward	<input type="checkbox"/> Sits well
<input type="checkbox"/> Good Head control	<input type="checkbox"/> Rolls over	<input type="checkbox"/> Crawls
<input type="checkbox"/> Symmetry in movements	<input type="checkbox"/> Uses visual exploration	<input type="checkbox"/> Pulls to feet with support
<input type="checkbox"/> Begins to roll and reach for objects	<input type="checkbox"/> Beginning to use oral exploration	<input type="checkbox"/> Peekaboo
<input type="checkbox"/> Responds to affection	<input type="checkbox"/> Uses a string of vowels (ah, eh, oh)	<input type="checkbox"/> Objects permanence
<input type="checkbox"/> Indicates pleasure or displeasure	<input type="checkbox"/> Beginning to recognize own name	<input type="checkbox"/> Looks at book
<input type="checkbox"/> Spontaneous expressive babbling	<input type="checkbox"/> Enjoys vocal turn taking	<input type="checkbox"/> Imitates sounds
<input type="checkbox"/> Social smile	<input type="checkbox"/> Shows pleasure from interaction with parents or others	<input type="checkbox"/> Points out objects
<input type="checkbox"/> Elicits social interactions		<input type="checkbox"/> Stranger anxiety
<input type="checkbox"/> Smiles spontaneously		<input type="checkbox"/> Seeks parent for comfort
<input type="checkbox"/> Can calm down on own		
12 MONTH	15 MONTH	18 MONTH
COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	***COMPLETE ATTACHED M-CHAT-R*** ***AGES AND STAGES QUESTIONNAIRE (ASQ)***
If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child for the correct age visit:		
<input type="checkbox"/> Waves bye-bye	<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house
<input type="checkbox"/> Tries to do what you do	<input type="checkbox"/> Helps in the house	<input type="checkbox"/> Laughs in response to others
<input type="checkbox"/> Cries when you leave	<input type="checkbox"/> Listens to a story	<input type="checkbox"/> Speaks 6 words
<input type="checkbox"/> Plays Peekaboo	<input type="checkbox"/> Says 2 to 3 words	<input type="checkbox"/> Knows names of favorite books
<input type="checkbox"/> Hands you a book to read	<input type="checkbox"/> Scribbles	<input type="checkbox"/> Points to 1 body part
<input type="checkbox"/> Speaks 1-2 words	<input type="checkbox"/> Follows simple commands	<input type="checkbox"/> Stacks 2 small blocks
<input type="checkbox"/> Babbles	<input type="checkbox"/> Bends down without falling	<input type="checkbox"/> Runs
<input type="checkbox"/> Tries to make the same sounds you do	<input type="checkbox"/> Walks well	<input type="checkbox"/> Walk up steps
<input type="checkbox"/> Looks at things you are looking at	<input type="checkbox"/> Puts blocks in a cup	<input type="checkbox"/> Uses spoon and cup without spilling most of the time
<input type="checkbox"/> Follows simple directions	<input type="checkbox"/> Puts block in a cup	
<input type="checkbox"/> Bangs toys together	<input type="checkbox"/> Drinks from cup with very little spilling	

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE _____ SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
 AHMTA was not accessible during this patient visit. Reviewed note & agree _____ *(Provider Initial)*

VISIT FOR: : Acute Well Child Visit 3-5 day/1 week 1 Month 2 Months 4 Months
 6 Months 9 Months 12 Months 15 Months 18 Months

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Cough	<input type="checkbox"/> Poor Weight Gain
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hearing Concerns
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Earache	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Snoring
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Decrease in Appetite	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Rash	<input type="checkbox"/> Excessive Thirst

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> EOMI, RR X2, NI corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> NI pinna/ext ear canal <input type="checkbox"/> TM gray/NI landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no cleft or pit	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, NI WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, <input type="checkbox"/> no sacral dimple	<input type="checkbox"/> Sacral Dimple
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash, No bruises	<input type="checkbox"/> Jaundice
<input type="checkbox"/>	Hips:	<input type="checkbox"/> Full ROM, <input type="checkbox"/> Neg Barlow <input type="checkbox"/> Neg Ortolani	<input type="checkbox"/> Hip click <input type="checkbox"/> Hip clunk
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female/no adhesions <input type="checkbox"/> NI male, Testes down B/L	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS: Hip U/S Spine U/S

A/P: Well baby: normal growth & development for age
 400 IU Vitamin D supplement/day Infant Multivitamin 1 ml per day Triple paste to diaper area Q diaper change

F/U: at next well child visit at _____ months, or sooner if parental concerns
 Patient and/or parent verbalizes understanding of treatment and plan
 Anticipatory guidance/Prevention handout provided



Questions about your child's development?

Educational & Developmental Intervention Services (EDIS)

is a program for infants and toddlers (birth to 36 months) who have:

- medical conditions which may affect development (such as complications of prematurity, hearing or visual impairment)
- developmental delay (for example, not walking or talking as expected) or atypical development
- genetic conditions

Educational & Developmental Intervention Services provides:

- in-home services
- basic services are free to eligible children:
 - * developmental evaluation (includes physical, communication, problem-solving, self-help, and social-emotional skills)
 - * in-home training for parents on encouraging child's development
 - * service coordination (helps parents access other services)

Parents can refer their children!

To make a referral, call:

(for families living on base:)

**Educational & Developmental
Intervention Services**
Location: NH200 Annex
Naval Hospital Camp Lejeune
Mailing Address:
EDIS
100 Brewster Blvd
Camp Lejeune, NC 28547
910 450 4127

(for families living off base:)

Children's Developmental Services Agency
2842 Neuse Blvd
New Bern, NC 28562
866 KIDS N NC (toll free)
866 543 7662