



# Bright Futures Parent Handout 18 Month Visit

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

LANGUAGE PROMOTION/HEARING

## Talking and Hearing

- Read and sing to your child often.
- Talk about and describe pictures in books.
- Use simple words with your child.
- Tell your child the words for her feelings.
- Ask your child simple questions, confirm her answers, and explain simply.
- Use simple, clear words to tell your child what you want her to do.

## Your Child and Family

- Create time for your family to be together.
- Keep outings with a toddler brief—1 hour or less.
- Do not expect a toddler to share.
- Give older children a safe place for toys they do not want to share.
- Teach your child not to hit, bite, or hurt other people or pets.
- Your child may go from trying to be independent to clinging; this is normal.
- Consider enrolling in a parent-toddler playgroup.
- Ask us for help in finding programs to help your family.
- Prepare for your new baby by reading books about being a big brother or sister.
- Spend time with each child.
- Make sure you are also taking care of yourself.
- Tell your child when he is doing a good job.
- Give your toddler many chances to try a new food. Allow mouthing and touching to learn about them.
- Tell us if you need help with getting enough food for your family.

FAMILY SUPPORT

## Safety

- Use a car safety seat in the back seat of all vehicles.

SAFETY

SAFETY

- Read the instructions about your car safety seat to check on the weight and height requirements.
- Everyone should always 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.
- Move furniture away from windows.
- Watch your child closely when she is on the stairs.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so he is not run over.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Prevent burns by keeping hot liquids, matches, lighters, and the stove away from your child.
- Have a working smoke detector on every floor.

## Toilet Training

- Signs of being ready for toilet training include
  - Dry for 2 hours
  - Knows if he is wet or dry
  - Can pull pants down and up
  - Wants to learn
  - Can tell you if he is going to have a bowel movement
- Read books about toilet training with your child.

TOILET-TRAINING READINESS

TOILET-TRAINING READINESS

CHILD DEVELOPMENT AND BEHAVIOR

- Have the parent of the same sex as your child or an older brother or sister take your child to the bathroom.
- Praise sitting on the potty or toilet even with clothes on.
- Take your child to choose underwear when he feels ready to do so.

## Your Child's Behavior

- Set limits that are important to you and ask others to use them with your toddler.
- Be consistent with your toddler.
- Praise your child for behaving well.
- Play with your child each day by doing things she likes.
- Keep time-outs brief. Tell your child in simple words what she did wrong.
- Tell your child what to do in a nice way.
- Change your child's focus to another toy or activity if she becomes upset.
- Parenting class can help you understand your child's behavior and teach you what to do.
- Expect your child to cling to you in new situations.

## What to Expect at Your Child's 2 Year Visit

### We will talk about

- Your talking child
- Your child and TV
- Car and outside safety
- Toilet training
- How your child behaves

Poison Help: 1-800-222-1222

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



## American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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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	0 No Hurt	1 Hurts Little Bit	2 Hurts Little More
					3 Hurts Even More
					4 Hurts Whole Lot
					5 Hurts Worst

(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 <input type="checkbox"/> No <input type="checkbox"/> Yes describe: _____ Group B Strep. (GBS) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Don't Know Type of Delivery (check all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum-assisted <input type="checkbox"/> C-section <input type="checkbox"/> Breech Complications at birth? Jaundice * <input type="checkbox"/> Yes <input type="checkbox"/> No Phototherapy * <input type="checkbox"/> Yes <input type="checkbox"/> No Hip Click/Clunk * <input type="checkbox"/> Yes <input type="checkbox"/> No Other: _____ Did your child receive the Hepatitis B vaccine at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Newborn Metabolic Screen Submitted: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Repeated Baby's Hearing Screen: <input type="checkbox"/> Passed Bilateral <input type="checkbox"/> Repeat Needed <input type="checkbox"/> Don't Know  Clinic Use Only - For Newborns-2 weeks Complete Risk assessment for Jaundice (Bill and Blood Type)
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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 1 week, 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"/> Billirubin (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/TCx	<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) COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	1 MONTH COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	2 MONTH 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 COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	6 MONTH COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	9 MONTH ***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 of 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 COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	15 MONTH COMPLETE ATTACHED AGES AND STAGES QUESTIONNAIRE (ASQ)	18 MONTH ***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)*

AHLTA 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, ni 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

## M-CHAT

Please fill out the following about how your child usually is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.

1. Does your child enjoy being swung, bounced on your knee, etc.? Yes No
2. Does your child take an interest in other children? Yes No
3. Does your child like climbing on things, such as up stairs? Yes No
4. Does your child enjoy playing peek-a-boo/hide-and-seek? Yes No
5. Does your child ever pretend, for example, to talk on the phone or take care of a doll or pretend other things? Yes No
6. Does your child ever use his/her index finger to point, to ask for something? Yes No
7. Does your child ever use his/her index finger to point, to indicate interest in something? Yes No
8. Can your child play properly with small toys (e.g. cars or blocks) without just mouthing, fiddling, or dropping them? Yes No
9. Does your child ever bring objects over to you (parent) to show you something? Yes No
10. Does your child look you in the eye for more than a second or two? Yes No
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) Yes No
12. Does your child smile in response to your face or your smile? Yes No
13. Does your child imitate you? (e.g., you make a face-will your child imitate it?) Yes No
14. Does your child respond to his/her name when you call? Yes No
15. If you point at a toy across the room, does your child look at it? Yes No
16. Does your child walk? Yes No
17. Does your child look at things you are looking at? Yes No
18. Does your child make unusual finger movements near his/her face? Yes No
19. Does your child try to attract your attention to his/her own activity? Yes No
20. Have you ever wondered if your child is deaf? Yes No
21. Does your child understand what people say? Yes No
22. Does your child sometimes stare at nothing or wander with no purpose? Yes No
23. Does your child look at your face to check your reaction when faced with something unfamiliar? Yes No



## 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