*Nassau County Department of Health*
***EARLY INTERVENTION PROGRAM*** **Fax (516) 227-8662**

# HEALTH STATUS REPORT

In compliance with the New York State Early Intervention Regulations Section 69-4.8(4)(I)(a), a physical examination is required as part of the initial multidisciplinary evaluation including a routine vision & hearing screening.

Child's Name _____ SEX: F M Date of Birth _____/_____/_____

Birth Weight: _____ Place of Birth: _____

**Significant Family Medical/Social History** (Explain)

Vision_____ Hearing_____

TB _____Chronic Illnesses_____

Social Concerns: _____

Exposure to Violence: _____

High Risk Birth/Complications: _____

**Complete Physical Examination**

Date of Examination: _____/_____/_____

Height: _____ Weight: _____Percentile: _____

Head Circumference: _____ B / P : _____/_____

Nutritional Concerns:_____

Current Medications:_____

**IMMUNIZATION HISTORY**
DATE IMMUNIZATION GIVEN

| | 1st | 2nd | 3rd | 4th | 5th |
|---|---|---|---|---|---|
| HEP B | | | | | |
| DTP | | | | | |
| HIB | | | | | |
| POLIO | | | | | |
| MMR | | | | | |
| VARICELLA | | | | | |
| PNUMOCOCCAL | | | | | |
| INFLUENZA | | | | | |
| HEPATITIS A | | | | | |

**ALLERGIES**

- ☐ None
- ☐ Food_____
- ☐ Medicine_____
- ☐ Other_____

**LEAD TEST HISTORY**

| | DATE | RESULT |
|---|---|---|
| ONE YEAR | | |
| TWO YEARS | | |
| OTHER | | |

**DEVELOPMENTAL OBSERVATIONS** – Please complete for each age level by placing a check in each area. Indicate any action or follow-up necessary.

**BY 6 MONTHS:**
____Imitates vocalizing
____Turns to voice
____Rolls over
____Reaches (ea. Hand)
____Cuddles

____AVOIDS EYE CONTACT

**BY 12 MONTHS:**
____Stands alone 2 secs.
____Bangs two blocks
____Says "Mama/Dada" specifically
____Responds to "no"
____Plays patty cake or waves "bye-bye"

____AVOIDS EYE CONTACT

____CONCERN THAT CHILD CAN'T HEAR

____TUNES OUT

**BY 18 MONTHS:**
____Imitates household chores (sweeping)
____Says 4 words besides "Mama/Dada"
____Points to one body part "show me your nose"
____Drinks from a cup
____Scribbles

____AVOIDS EYE CONTACT

____TOE WALKING

**BY 2 YEARS:**
____Kicks ball forward
____Combines 2 words
____Strangers understand half child's speech
____Points to 6 named body parts (nose, eyes…)
____Names 1 animal picture
____Takes off clothing (other than hat)

PERSISTENT:
____ROCKING

____HEADBANGING

**BY 3 YEARS:**
____Holds 2-3 sentence conversation
____Names 4 animal pictures
____Knows 2 animal actions -flies, meows?
____Understands what to do when tired, cold or hungry (1 of 3)
____Imitates vertical line

____Washes & dries hands
____ECHOLALIA (repeating what was just said)
____HANDFLAPPING

# PARENTAL CONSENT TO OBTAIN/RELEASE INFORMATION

Child's Name:_____ Date of Birth:____/____/____

I, _____, give my consent to have my child's records released to
Name of Parent/Guardian (Please Print)

Nassau County Department of Health Early Intervention Program.

_____ _____
Signature of Parent/Guardian Date

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# PHYSICIAN RECOMMENDATIONS & REFERRALS

Please indicate which of the medical specialty areas this child has visited or been referred:

| | Referred | Date Visited |
|---|---|---|
| Developmental Pediatrician | _____ | _____ |
| Visual/ Ophthalmologist | _____ | _____ |
| ENT/Hearing | _____ | _____ |
| Neurologist | _____ | _____ |
| Cardiologist | _____ | _____ |
| Orthopedist/ Physiatrist | _____ | _____ |
| Neo-Natal Spec. | _____ | _____ |
| Gastro-Intestinal | _____ | _____ |
| Genetic Testing | _____ | _____ |
| Audiological | _____ | _____ |
| Physical Thpy. | _____ | _____ |
| Occupational Thpy: | _____ | _____ |
| Speech Thpy. | _____ | _____ |

**CLINICAL IMPRESSIONS & RECOMMENDATIONS**

Indicate all chronic conditions and/or findings needing follow-up:

1. _____

2. _____

**DIAGNOSIS & ICD 10 CODE:**

_____

_____

This child is being referred because he/she is suspected of having a disability, which includes a developmental delay and/or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

_____
Physician Signature

Print Name_____

Address_____

_____

Phone No._____

License No._____

Physician NPI No._____

## Completed Form may be Faxed to (516) 227- 8662

(Include confidentiality cover sheet)