

Child's Name \_\_\_\_\_

Filled out by: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to child \_\_\_\_\_

Today's date \_\_\_\_\_

## Modified Checklist for Autism in Toddlers (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 dolls, 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 bricks) 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
21.	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

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<http://www.dbpediatrics.org/media/mchat>

# Londonderry Pediatrics Tuberculosis Risk Assessment

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date \_\_\_\_\_

Please read the questions and circle the answer that applies to your child.

1) Are there any household members who have recently been treated for TB?

YES                  NO

2) Are you aware of any cases of TB in your neighborhood?

YES                  NO

3) Does your child have a problem with his or her immune system?

YES                  NO

4) Has your child ever lived in a foreign country?

YES                  NO

5) If you answered YES to question #4, has your child ever received BCG vaccine for TB?

YES                  NO

\_\_\_\_\_  
Name of parent/guardian

\_\_\_\_\_  
Relationship

Please bring the completed form to your child's well visit. Thank you.

# Londonderry Pediatrics Lead Risk Assessment

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date \_\_\_\_\_

Please read the questions and circle the answer that applies to your child.

- 1) Does your child live in or regularly visit a house or child care facility built before 1950?

YES                      NO                      Don't Know

- 2) Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled?

YES                      NO                      Don't Know

- 3) Does your child have a sibling or playmate that has or did have lead poisoning?

YES                      NO                      Don't Know

- 4) Is your child enrolled in Healthy Kids Gold?

YES                      NO                      Don't Know

- 5) Is your child enrolled in the WIC program?

YES                      NO                      Don't Know

- 6) Does your child attend daycare in Massachusetts?

YES                      NO                      Don't Know

\_\_\_\_\_  
Name of parent/guardian

\_\_\_\_\_  
Relationship

Please bring the completed form to your child's well visit. Thank you.

Londonderry Pediatrics, PA  
25 Buttrick Road, Bldg. E  
Londonderry, NH 03053

## VFC Eligibility

Children through 18 years of age who meet at least one of the following criteria are considered federally vaccine-eligible and therefore eligible to participate in the VFC program:

- **Medicaid eligible:** A child who is eligible for the Medicaid program. (For the purposes of the VFC program the terms Medicaid-eligible and Medicaid-enrolled are equivalent and refer to children who have health insurance covered by a state Medicaid program)
- **Uninsured:** A child who has no health insurance coverage
- **Indian (American Indian or Alaska Native):** As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- **Underinsured:** Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC - eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount--once that coverage amount is reached, these children are categorized as underinsured. **Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).**

Name:

\_\_\_\_\_

Last,	First,	MI	Birth date	Age
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Signature \_\_\_\_\_

Is enrolled in Medicaid	Yes	No	Date
Is Native American	Yes	No	Date
Doesn't have insurance	Yes	No	Date
Is Underinsured (Insurance does not cover the cost of vaccines)	Yes	No	Date