



Person Completing Form: _____

Pediatric Cardiac Risk Assessment Form

Complete this form for each person under the age of 50, including children, periodically during well child visits including neonatal, preschool, before and during middle school, before and during high school, before college and every few years through adulthood. *If you answer "Yes" or "Unsure" to any questions, read the back of this form.*

Updated 05.11.17

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Print Name

East Cobb Pediatrics & Adolescent Medicine, P.C.

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Georgia Healthy Homes and Lead Poisoning Prevention Program

Patients Name	 	_ Date of Birth

Risk Factors Assessment Questionnaire

- 1. Does your child live in or often visit a house that may have been built before 1978?
- 2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint removed?
- 3. Does your child live with or often visit another child that had or has an elevated blood lead level?
- 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
- 5. Does your child chew on or eat non-food items like paint chips or dirt?
- 6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
- 7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tests should be done immediately if the child is at high

risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

Marietta: 1121 Johnson Ferry Road, Suite 220, Marietta, GA 30068 ph: 770-977-0094 fax: 770-509-9463 Kennesaw: 6110 Pine Mountain Road, Suite 202, Kennesaw, GA 30152 ph: 770-795-4553 fax: 770-795-4513

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Deanna Fetsch, CPNP
Barbara Cossman, CPNP
Shelly Brown, CPNP

Parent Instructions for PEDS Form

- This form is a Parent's Evaluation of Developmental Status and helps to ensure that your child is progressing appropriately for their age.
- On the first question, please list any concerns that you have about your child. If you have no concerns, please write that on the form.
- For the remaining questions, answer yes or A little if you have the concern now or have had it in the past, even if it has improved. Please comment what the concern is or was.
- Answer No to the following questions if you have never had a concern about that question.
- Once completed, please give this form to the medical assistant or nurse that takes you back to the clinical area. If you have any questions, they will be happy to help you.

Thank you for completing the form.

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To ACCURATELY score PEDS Providers MUST USE Score/Longitudinal Interpretation Forms and Brief Guide to Administration

Y			PEDS	RESP	ONSE F	ORM	
Chil Pa Massa	L				arent's Name		Provider
					·	# 1 1 D	
				Child's Age_		Today's Date	
Please list ar	iy concei	rns about	your child's	learning, developme	nt, and behavior.		
Do you have	any cor			child talks and ma	kes speech sounds?]	
Circle one:	No	Yes	A little	COMMENTS:			
Do you have	any cor	ncerns ab	out how your	child understands 1	vhat you say?		
Circle one:	No	Yes	A little	COMMENTS:	· · · · · · · · · · · · · · · · · · ·		
Do vou have	any con	acerns ab	out how vour	child uses his or her	r hands and finger.	s to do things?	
Circle one:	No	Yes	A little	COMMENTS;	<u> </u>		
Do you have	e any con	ncerns ab	out how your	r child uses his or her	r arms and legs?		
Circle one:	No	Yes	A little	COMMENTS:			
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Do you have	e any cor	ncerns ab	out how you	r child gets along wi	th others?		
Circle one:	No	Yes	A little	COMMENTS:			
Do vou have	e anv cor	ncerns ah	out how you	r child is learning to	do things for him.	self/herself?	
Circle one:	No	Yes	A little	COMMENTS:			
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				r child is learning pr	reschool or school s	kills?	
Circle one:	No	Yes	A little	COMMENTS:			
Please list a	ny other	concerns					

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Date Child's name Relationship to child Age M-CHAT-R[™] (Modified Checklist for Autism in Toddlers Revised) Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank you very much. Yes No 1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?) 2. Have you ever wondered if your child might be deaf? Yes No Yes No 3. Does your child play pretend or make-believe? (For Example, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) 4. Does your child like climbing on things? (For Example, furniture, playground Yes No equipment, or stairs) 5. Does your child make unusual finger movements near his or her eyes? Yes No (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?) 6. Does your child point with one finger to ask for something or to get help? Yes No (FOR EXAMPLE, pointing to a snack or toy that is out of reach) 7. Does your child point with one finger to show you something interesting? Yes Nο (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road) 8. Is your child interested in other children? (FOR EXAMPLE, does your child watch Yes No other children, smile at them, or go to them?) 9. Does your child show you things by bringing them to you or holding them up for you to Yes No see - not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck) 10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she Yes Νo look up, talk or babble, or stop what he or she is doing when you call his or her name?) 11. When you smile at your child, does he or she smile back at you? Yes No 12. Does your child get upset by everyday noises? (For Example, does your Yes No child scream or cry to noise such as a vacuum cleaner or loud music?) Yes No 13. Does your child walk? 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? 15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or No Yes make a funny noise when you do) 16. If you turn your head to look at something, does your child look around to see what you Yes No are looking at? 17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child Yes No look at you for praise, or say "look" or "watch me"?) 18. Does your child understand when you tell him or her to do something? Yes No (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?) 19. If something new happens, does your child look at your face to see how you feel about it? Yes No (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) Yes No 20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)

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