Screening Protocol at AnMed Health’s Children’s Health Center

Deandra Clark, MD
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- I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

- I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
Pre–QTIP: We only performed Teen Screen (PSC–Y 35)

Post–QTIP:
- We initiated in rapid succession
  - Edinburg Maternal depression screen
  - PEDS response form
  - M–CHAT
- Over time we have added additional screen
  - SEEK
  - Oral Health Risk Assess
  - Asthma Control test
Pre– and Post–QTIP

- PHQ–9
- SCARED
- Mood Disorder Questionnaire (MDQ– aka Mania Screen)
- Transition Readiness Checklist
- Suicidal Behaviors Questionnaire (SBQ–R)
  - Practice decided only one screen per WCC visit
Screens at WCC
Risk Assessments
(99420)
Edinburgh Maternal Depression Screens

Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ___________________________ Address: ___________________________

Your Date of Birth: ___________ Baby’s Date of Birth: ___________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time
- No, not very often
- No, not at all

In the past 7 days:
1. I have been able to laugh and see the funny side of things
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4. I have been anxious or worried for no good reason
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

*5. I have felt scared or panicky for no very good reason
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

*6. Things have been getting on top of me
- Yes, most of the time I haven’t been able
to cope at all
- Yes, sometimes I haven’t been coping as well
- as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

*8. I have felt sad or miserable
- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

*9. I have been so unhappy that I have been crying
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

*10. The thought of harming myself has occurred to me
- Yes, quite often
- Sometimes
- Hardly ever
- Never

Administered/Reviewed by ___________ Date ___________


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Safe Environment for Every Kid (SEEK) Screen

The Parent Screening Questionnaire

Dear Parent or Caregiver: Being a parent is not always easy.

We want to help families have a safe environment for kids. So, we’re asking everyone these questions. They are about problems that affect many families. If there’s a problem, we’ll try to help.

Please answer the questions about your child being seen today for a checkup. If there’s more than one child, please answer “yes” if it applies to any one of them. This is voluntary. You don’t have to answer any question you prefer not to.

Child’s Name: ______________________ Today’s Date: __/__/____
Child’s Date of Birth: __/__/____

PLEASE CHECK

- Yes □ No □ Do you need the phone number for Poison Control?
- Yes □ No □ Do you need a smoke detector for your home?
- Yes □ No □ Does anyone smoke tobacco at home?
- Yes □ No □ In the last year, did you worry that your food would run out before you got money or Food Stamps to buy more?
- Yes □ No □ In the last year, did the food you bought just not last and you didn’t have money to get more?
- Yes □ No □ Do you often feel your child is difficult to take care of?
- Yes □ No □ Do you sometimes find you need to hit/spank your child?
- Yes □ No □ Do you wish you had more help with your child?
- Yes □ No □ Do you often feel under extreme stress?
- Yes □ No □ In the past month, have you often felt down, depressed, or hopeless?
- Yes □ No □ In the past month, have you felt very little interest or pleasure in things you used to enjoy?
- Yes □ No □ In the past year, have you been afraid of your partner?
- Yes □ No □ In the past year, have you had a problem with drugs or alcohol?
- Yes □ No □ In the past year, have you felt the need to cut back on drinking or drug use?
- Yes □ No □ Are there any other problems you’d like help with today?

Please give this form to the doctor or nurse you’re seeing today. Thank you!
Oral Health Risk Assessment (OHRA)

Oral Health Risk Assessment Tool

The American Academy of Pediatrics (AAP) has developed this tool to aid in the implementation of oral health risk assessment during health supervision visits. This tool has been subsequently reviewed and endorsed by the National Interprofessional Initiative on Oral Health.

Instructions for Use

This tool is intended for documenting caries risk of the child, however, two risk factors are based on the mother or primary caregiver's oral health. All other factors and findings should be documented based on the child.

The child is at an absolute high risk for caries if any risk factors or clinical findings, marked with a △ sign, are documented yes. In the absence of △ risk factors or clinical findings, the clinician may determine the child is at high risk of caries based on one or more positive responses to other risk factors or clinical findings. Answering yes to protective factors should be taken into account with risk factors/clinical findings in determining low versus high risk.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit: 6 month</td>
<td>12 month</td>
</tr>
<tr>
<td>Date:</td>
<td>6 year</td>
</tr>
</tbody>
</table>

### Risk Factors

- Mother or primary caregiver had active decay in the past 12 months
  - Yes □ No □
- Mother or primary caregiver does not have a dentist
  - Yes □ No □
- Continual bottle/sippy cup use with fluid other than water
  - Yes □ No □
- Frequent snacking
  - Yes □ No □
- Special health care needs
  - Yes □ No □
- Medicaid eligible
  - Yes □ No □

### Protective Factors

- Existing dental home
  - Yes □ No □
- Drinks fluoridated water or takes fluoride supplements
  - Yes □ No □
- Fluoride varnish in the last 6 months
  - Yes □ No □
- Has teeth brushed twice daily
  - Yes □ No □

### Clinical Findings

- White spots or visible decalcifications in the past 12 months
  - Yes □ No □
- Obvious decay
  - Yes □ No □
- Restorations (fillings) present
  - Yes □ No □
- Visible plaque accumulation
  - Yes □ No □
- Gingivitis (swollen/bleeding gums)
  - Yes □ No □
- Teeth present
  - Yes □ No □
- Healthy teeth
  - Yes □ No □

### Assessment/Plan

- Caries Risk:
  - Low □ High □
- Completed:
  - Anticipatory Guidance □ Fluoride Varnish □ Dental Referral □
- Self Management Goals:
  - Regular dental visits □ Dental treatment for parents □ Brush twice daily □ Use fluoride toothpaste □
- Treatment of High Risk Children
  - If appropriate, high-risk children should receive professionally applied fluoride varnish and have their teeth brushed twice daily with an age-appropriate amount of fluoridated toothpaste. Referral to a pediatric dentist or a dentist comfortable caring for children should be made with follow-up to ensure that the child is being cared for in the dental home.

American Academy of Pediatrics
INDICATED TO THE HEALTH OF ALL CHILDREN®

Bright Futures
National Interprofessional Initiative on Oral Health


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Developmental Screens (96110)
# Peds Response Form

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Please list any concerns about your child's learning, development,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and behaviour.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any concerns about how your child talks and makes speech</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>sounds?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>3. Do you have any concerns about how your child understands what you</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>say?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>4. Do you have any concerns about how your child uses his or her hands</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>and fingers to do things?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>5. Do you have any concerns about how your child uses his or her arms</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>and legs?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>6. Do you have any concerns about how your child behaves?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>7. Do you have any concerns about how your child gets along with others</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any concerns about how your child is learning to do</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>things for himself/herself?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>9. Do you have any concerns about how your child is learning preschool</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>or school skills?</td>
<td>A little</td>
<td></td>
</tr>
<tr>
<td>Circle one: No, Yes, A little</td>
<td>COMMENTS:</td>
<td></td>
</tr>
<tr>
<td>10. Please list any other concerns.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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M–CHAT–R™

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.

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?)
   - Yes
   - No

2. Have you ever wondered if your child might be deaf?
   - 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?)
   - Yes
   - No

4. Does your child like climbing on things? (For example, furniture, playground equipment, or stairs)
   - Yes
   - No

5. Does your child make unusual finger movements near his or her eyes? (For example, does your child wiggle his or her fingers close to his or her eyes?)
   - Yes
   - No

6. Does your child point with one finger to ask for something or to get help? (For example, pointing to a snack or toy that is out of reach)
   - Yes
   - No

7. Does your child point with one finger to show you something interesting? (For example, pointing to an airplane in the sky or a big truck in the road)
   - Yes
   - No

8. Is your child interested in other children? (For example, does your child watch other children, smile at them, or go to them?)
   - Yes
   - No

9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (For example, showing you a flower, a stuffed animal, or a toy truck)
   - Yes
   - No

10. Does your child respond when you call his or her name? (For example, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)
    - Yes
    - No

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 child scream or cry to noise such as a vacuum cleaner or loud music?)
    - Yes
    - No

13. Does your child walk?
    - Yes
    - No

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?
    - Yes
    - No

15. Does your child try to copy what you do? (For example, wave bye-bye, clap, or make a funny noise when you do)
    - Yes
    - No

16. If you turn your head to look at something, does your child look around to see what you are looking at?
    - Yes
    - No

17. Does your child try to get you to watch him or her? (For example, does your child look at you for praise, or say “look” or “watch me”?)
    - Yes
    - No

18. Does your child understand when you tell him or her to do something? (For example, if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?)
    - Yes
    - No

19. If something new happens, does your child look at your face to see how you feel about it? (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)
    - Yes
    - No
# PSC-Y (Teen Screen)

A Survey From Your Healthcare Provider — PSC-Y

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please mark under the heading that best fits you or circle Yes or No</td>
<td>Never</td>
<td>Sometimes 1</td>
</tr>
<tr>
<td>1. Complain of ache or pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Spend more time alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Tire easily, little energy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Fidgety, unable to sit still</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have trouble with teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Less interested in school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Act as if driven by motor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Daydream too much</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Distress easily</td>
<td></td>
<td></td>
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<tr>
<td>10. Are afraid of new situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Feel sad, unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Are irritable, angry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Feel hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have trouble concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Less interested in friends</td>
<td></td>
<td></td>
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<tr>
<td>16. Fight with other children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Absent from school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. School grades dropping</td>
<td></td>
<td></td>
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<tr>
<td>19. Down on yourself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Visit doctor with doctor finding nothing wrong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have trouble sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Worry a lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Want to be with parent more than before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Feel that you are bad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Take unnecessary risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Get hurt frequently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Seem to be having less fun</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Act younger than children your age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Do not listen to rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Do not show feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Do not understand other people’s feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Tease others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Blame others for your troubles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Take things that do not belong to you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Refuse to share</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. During the past three months, have you thought of killing yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>37. Have you ever tried to kill yourself?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

FOR OFFICE USE ONLY

- Plan for follow-up
- Annual screening
- Return visit w/ PCP
- Parent declined
- Already in treatment
- Referred to counselor
- Referred to other professional

Q 36 or Q 37 = Y

TS ≥ 30

Source: Pediatric Symptom Checklist — Youth Report (PSC-Y)
## Transition Readiness Checklist

**Patients Name ____________________________**

This checklist is to help you get ready for managing your own health care. It is for you and your parent or caregiver to complete together. Please check which best describes your current abilities.

### Knowing About My Health

1. I know what my health needs or disabilities are and can explain them.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

2. I know what symptoms need quick attention.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

3. I know what to do in case I have an emergency.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

### Taking Charge of My Health

1. I carry my health insurance card with me everyday.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

2. I carry my health summary with me every day (including a list of medications and allergies and my doctor's phone number).
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

3. I call for my own doctor appointments.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

4. I know that I can see the doctor by myself if I want to.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

5. I can discuss my health care needs with the doctor or nurse myself.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

6. I track my own medicine refills and can call for refills.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

7. I help take care of my medical equipment so it's in good working condition.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

8. I know how to prevent pregnancy and sexually transmitted diseases (STDs).
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

9. I know how smoking, drugs, or alcohol use can impact my health.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

### Getting Ready for Independent Living

1. I know how to use appliances in the home.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

2. I can wash my own clothes.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

3. I can clean my room.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

4. I can discuss my IEP or 504 plan with the school.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

5. I am planning for further education or a job.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

6. I know how to apply for a job or contact Vocational Rehab for help.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

7. I know what housing opportunities there are for independent living.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

8. I am able to do my transfers and get around in my home.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this

9. I know how to get from one place to another in town.
   - [ ] Can already do this
   - [ ] Need practice doing this
   - [ ] Want to learn to do this
   - [ ] Someone else will have to do this
Screens done for other appointment types
ADHD Assessment and Follow-up
Evaluation:
- Parent evaluation form
- Teacher evaluation form

Follow-up:
- Parent follow-up form
- Teacher follow-up form
done at discretion of provider
Depression/Anxiety Evaluation and Follow-up
# PHQ–9 Depression Screen

![PHQ-9 Modified for Teens](image)

**Instructions:** How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom, put an “X” in the box beneath the answer that best describes how you have been feeling.

<table>
<thead>
<tr>
<th></th>
<th>Not At All</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble sleeping, staying asleep, or sleeping too much?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Poor appetite, weight loss or overeating?</td>
<td></td>
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<tr>
<td>5. Feeling tired, having little energy?</td>
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<tr>
<td>6. Feeling sad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td></td>
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<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed?</td>
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<tr>
<td>9. Track of things or being so fidgety or restless that you were moving around a lot more than usual?</td>
<td></td>
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<tr>
<td>10. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
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</tbody>
</table>

In the past two weeks, have you felt depressed or sad most days, even if you felt okay sometimes?

- [ ] Yes
- [ ] No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

- [ ] Not difficult at all
- [ ] Somewhat difficult
- [ ] Very difficult
- [ ] Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?

- [ ] Yes
- [ ] No

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

- [ ] Yes
- [ ] No

**Office use only:**

Severe score:

Modified with permission by the GLAICPC team from the PHQ-9 (Spitzer, Williams, & Kazee, 1999), Revised PHQ-9 (Johnson, 2012), and the CSH (DHS Development Group, 2005).

Use with Permisision: Guidelines for Adolescent Depression in Primary Care, Version 2.0000. 71
**Screen for Child Anxiety Related Disorders (SCARED)**

**CHILD Version—Page 1 of 2** (to be filled out by the CHILD)

**Developed by:** Boris Birmaher, M.D., Sumeeta Khurana, M.D., Marilyn Cully, M.D., David Brent, M.D., and Sandra McKenna, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaher@upmc.edu


### Directions:

Below is a list of 30 sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then, for each sentence, fill in the circle that corresponds to the response that seems to describe you for the last 3 months.

| 1. When I feel frightened, it is hard to breathe | 0 | 0 | 0 | PN |
| 2. I get headaches when I am at school. | 0 | 0 | 0 | SH |
| 3. I don’t like to be with people I don’t know well. | 0 | 0 | 0 | SC |
| 4. I get scared if I sleep away from home. | 0 | 0 | 0 | SP |
| 5. I worry about other people liking me. | 0 | 0 | 0 | GD |
| 6. When I get frightened, I feel like passing out. | 0 | 0 | 0 | PN |
| 7. I am nervous. | 0 | 0 | 0 | GD |
| 8. I follow my mother or father wherever they go. | 0 | 0 | 0 | SP |
| 9. People tell me that I look nervous. | 0 | 0 | 0 | PN |
| 10. I feel nervous with people I don’t know well. | 0 | 0 | 0 | SC |
| 11. I get stomachaches at school. | 0 | 0 | 0 | SH |
| 12. When I get frightened, I feel like I am going crazy. | 0 | 0 | 0 | PN |
| 13. I worry about sleeping alone. | 0 | 0 | 0 | SP |
| 14. I worry about being as good as other kids. | 0 | 0 | 0 | GD |
| 15. When I get frightened, I feel like things are not real. | 0 | 0 | 0 | PN |
| 16. I have nightmares about something bad happening to my parents. | 0 | 0 | 0 | SP |
| 17. I worry about going to school. | 0 | 0 | 0 | SH |
| 18. When I get frightened, my heart beats fast. | 0 | 0 | 0 | PN |
| 19. I get shaky. | 0 | 0 | 0 | SP |
| 20. I have nightmares about something bad happening to me. | 0 | 0 | 0 | SP |

### SCORING:

A total score of 25 or more indicates the presence of an Anxiety Disorder. Scores of 30 or more are more specific. **TOTAL** =

- A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatoform Symptoms: **PN** =
- A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder: **GD** =
- A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder: **SO** =
- A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder: **SC** =
- A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance: **SH** =

**For children ages 8 to 11, it is recommended that the clinician explains all questions, or have the child answer the questionnaires sitting with an adult in case they have any questions.**

The SCARED is available at no cost at [www.spec.pitt.edu/research tools and assessments](http://www.spec.pitt.edu/research tools and assessments), or at [www.pediatric bipolar pitt.edu under instruments](http://www.pediatric bipolar pitt.edu under instruments).
Suicidal Behaviors Questionnaire (SBQ–R)

SBQ–R Suicide Behaviors Questionnaire-Revised

Patient Name __________________________, Date of Visit ________________

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)
   □ 1. Never
   □ 2. It was just a brief passing thought
   □ 3a. I have had a plan at least once to kill myself but did not try to do it
   □ 3b. I have had a plan at least once to kill myself and really wanted to die
   □ 4a. I have attempted to kill myself, but did not want to die
   □ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)
   □ 1. Never
   □ 2. Rarely (1 time)
   □ 3. Sometimes (2 times)
   □ 4. Often (3–4 times)
   □ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)
   □ 1. No
   □ 2a. Yes, at one time, but did not really want to die
   □ 2b. Yes, at one time, and really wanted to die
   □ 3a. Yes, more than once, but did not want to do it
   □ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)
   □ 0. Never
   □ 1. No chance at all
   □ 2. Rather unlikely
   □ 3. Unlikely
   □ 4. Likely
   □ 5. Rather likely
   □ 6. Very likely

Asthma Control Test

Childhood Asthma Control Test for children 4 to 11 years.

How to take the Childhood Asthma Control Test:
1. Let your child respond to the first four questions (1 to 4). Be sure your child reads the scenarios carefully and understands the question, you may help, but not guide your child about this response. Count the scenarios three times (1 to 3) on your page and without telling your child, score the responses. Then, add up your child's responses and double it, it may be a sign of your child's asthma if not controlled as well as it could lead to serious complications. If your child answers yes to all, it may be a sign of your child's asthma is not controlled as well as it could be the best time to talk about your child's asthma.

How your child completes these questions:
1. How is your child today?
2. How much of the time do you have to take your child's asthma medication?
3. How much of the time do you have to take your child's asthma medication?
4. How much of the time do you have to take your child's asthma medication?

Please complete the following questions on your own.
5. During the last 4 weeks, how much of the time did your child have wheezing or asthma symptoms?
6. During the last 4 weeks, how often did your child wake up during the night because of asthma?
7. During the last 4 weeks, how often did your child need to use their inhaler because of asthma?
8. During the last 4 weeks, how often did your child have a cold because of asthma?

Asthma Control Test is:

- A quick test that provides a numerical score to assess asthma control.
- Recognized by the National Institutes of Health (NIH) in its 2020 asthma guidelines.
- Clinically validated against somatic and objective assessment.

PATIENTS:
1. Answer each question and write the answer number on the box to the right of each question.
2. Add up your answers and write your total score in the TOTAL box shown below.
3. Consult your results with your doctor.

1. In the past 4 weeks, how much of the time did your child have no symptoms, putting as much as daily, school or home?

2. During the last 4 weeks, how often has your child had chest tightness or breathlessness?

3. During the last 4 weeks, how often did your child wake up at night more than usual in the evening?

4. During the last 4 weeks, how often did your child use their rescue inhaler or quick relief medication (inhaled albuterol)?

5. How would you rate your child's asthma control during the past 4 weeks?

If your score is 19 or less, your child's asthma may be under control. Be sure to talk with your doctor about your results.

Copyright @2020 by the National Institutes of Health. (NIH) A revised version of the Childhood Asthma Control Test for children is being developed. The Adult Asthma Control Test is prepared with children 12 years and older.

### Screening Protocol: WCC

<table>
<thead>
<tr>
<th>Visit</th>
<th>Screen</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>2wk, 2mo, 4mo WCC</td>
<td>Edinburgh</td>
<td>99420</td>
</tr>
<tr>
<td>6mo WCC</td>
<td>SEEK</td>
<td>99420</td>
</tr>
<tr>
<td>9mo WCC</td>
<td>PEDS response, Oral Health (OHRA)</td>
<td>96110</td>
</tr>
<tr>
<td>12mo WCC</td>
<td>PEDS response</td>
<td>96110</td>
</tr>
<tr>
<td>15mo WCC</td>
<td>SEEK</td>
<td>99420</td>
</tr>
<tr>
<td>18mo, 24mo and 30mo WCC</td>
<td>M–CHAT–R</td>
<td>96110</td>
</tr>
<tr>
<td>3yr WCC</td>
<td>SEEK</td>
<td>99420</td>
</tr>
<tr>
<td>4yr WCC</td>
<td>PEDS response</td>
<td>96110</td>
</tr>
<tr>
<td>5yr WCC</td>
<td>SEEK</td>
<td>99420</td>
</tr>
<tr>
<td>11yr–13yr WCC</td>
<td>PSC–Y</td>
<td>96127</td>
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<tr>
<td>14yr–18yr WCC</td>
<td>PSC–Y, Transition readiness checklist</td>
<td>96127</td>
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</table>
# Screening Protocol: Other Visit Types

<table>
<thead>
<tr>
<th>Visit</th>
<th>Screen</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Vanderbilt</td>
<td>96127</td>
</tr>
<tr>
<td>Asthma</td>
<td>Asthma Control Test</td>
<td>99420 under 6yr</td>
</tr>
<tr>
<td>Depression/Anxiety</td>
<td>PHQ–9, SCARED, Suicidal Behavior Questionnaire (SBQ–R)</td>
<td>96127 (PHQ–9 and SCARED each)</td>
</tr>
</tbody>
</table>
Screens done on a Case–by–Case Basis
Other Screens

- Development
  - Ages and Stages
  - Strengths and Difficulties

- Depression/Anxiety/Bipolar
  - Mood Disorder Questionnaire
Mood Disorder Questionnaire (Mania Screen)

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...
   - you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?  
   - you were so irritable that you shouted at people or started fights or arguments?  
   - you felt much more self-confident than usual?  
   - you got much less sleep than usual and found you didn’t really miss it?  
   - you were much more talkative or spoke much faster than usual?  
   - thoughts raced through your head or you couldn’t slow your mind down?  
   - you were so easily distracted by things around you that you had trouble concentrating or staying on track?  
   - you had much more energy than usual?  
   - you were much more active or did many more things than usual?  
   - you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?  
   - you were much more interested in sex than usual?  
   - you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?  
   - spending money got you or your family into trouble?  

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.
   - No Problem  
   - Minor Problem  
   - Moderate Problem  
   - Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

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