UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention Program

Annual Health, Hearing & Vision Assessment

Health Assessment

Child Name: Parent/Guardian Name: Parent/Guardian Email:	Date of Birth: Current age: Gestation: Child ID:
Primary Care Physician: Regular Well-Child Checks? □ Yes □ No	PCP Phone/Fax: Most recent WCC:
Consulting Physicians:	Phone/Fax: Referred for testing?
Health Assessment Date: Health Assessor:	Records Review Date: Record Reviewer:

Growth		PCTL/BMI	Concerns and Resources	Immunization Status
Current Weight			Concerns about weight gain? Yes No Adequate access to food? □ Yes □ No WIC services? □ Yes □ No Special diet? □ Yes □ No Reflux? □ Yes □ No	☐ Current for age ☐ Not current but plans to get current ☐ Modified schedule ☐ Does not immunize
Current Length				

Medical Diagnosis Date	Medications/Supplements	Allergies
1.	1.	Medications:
2.	2.	Food:
3.	3.	Environmental:
4.	4.	Epi pen □ Yes □ No

Notes:

Feeding/Nutrition	Mealtime Routines
□ NG/NJ/GT feeds: □ Bottle/breast feeds: □ Vitamin D supplement □ Grains □ Fruit □ Veggies □ Protein □ Table foods □ Variety of textured foods □ Finger feeds □ Uses a spoon or fork □ Uses a cup □ Uses a sippy cup	How many meals and snacks? Where do they typically eat? What do they drink? Does child eat what the family eats? Difficulty chewing/swallowing? Does your child often cough or choke? Other:

Social-Emotional Wellness		Sleep Routines	
□ Calm alert state	□ Irritable	□ Reg bedtime	Bedtime:
□ Easy to comfort	□ Hard to calm	□ Sleeps all night	Wake time:
□ Seems happy	□ Seems sad	□ Wakes in the night	Avg naps/day:
□ Seeks affection	□ Avoids affection	□ Poor sleeper	Avg nap length:
□ Calms easily	□ Hyperactive	□ Snores	□ Crib □ Toddler bed
□ Interactive	□ Goes to anyone	□ Mouth breather	□ Sleeps alone
□ Avoids strangers		□ Back □ Stomach	□ Co-sleeps

Review of Systems

Neurology	Respiratory	Cardiac	Musculoskeletal
Mouth/Dental	HEENT	Skin	GI/GU

Notes:

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☐ Child has good general health. ☐ Assessor has health concerns about child. ☐ Concerns addressed by medical provider. ☐ Concerns NOT addressed by medical provider.

Has your child been hospitalized overnight or had surgery?
Has your child been referred to any new specialists?
Has your child been injured or needed to go to the ER?
Are you or anyone who knows your child concerned about autism?
Do you have any other concerns or information I should know that I did not ask about?

Notes:

Education provided:

Hearing Assessment

Newborn Hearing Screening: ☐ Pass ☐ Fail ☐ Unknown
CMV testing? ☐ Yes ☐ No
ENT referral? ☐ Yes ☐ No
Family history of childhood hearing loss? ☐ Yes ☐ No
Does your child respond to their name? ☐ Yes ☐ No
Can your child follow simple directions? ☐ Yes ☐ No

Follow-up hearing testing? ☐ Pass ☐ Fail
History of ear infections? ☐ Yes ☐ No How many?
PE tubes? ☐ Yes ☐ No Placement date:
Ear drainage or excessive wax? ☐ Yes ☐ No
Does your child respond to a whisper? ☐ Yes ☐ No
Is your child sensitive to certain noises? ☐ Yes ☐ No

Notes:

Hearing Summary	☐ **PASS** ☐ **REFER** ☐ **REFER TO USDB-PIP** ☐ **INCONCLUSIVE**			
Assessment	**Date**	**Provider:**	**Right Ear**	**Left Ear**
Audiology eval			☐ Pass ☐ Fail	☐ Pass ☐ Fail
OAE			☐ Pass ☐ Fail	☐ Pass ☐ Fail
Tympanogram			☐ Pass ☐ Fail	☐ Pass ☐ Fail

Annual Health, Hearing & Vision Assessment

Vision Assessment

Appearance of Eyes

- ☐ One eye looks different than other in size/shape
- ☐ One eyelid droops/appears lower than the other
- ☐ One/both eyes turns inward or outward
- ☐ Difference in pupil shape/size
- ☐ Difference in iris shape/size
- ☐ One/both eyes appear white or cloudy
- ☐ Rapid, involuntary eye movements
- ☐ Sclera red/yellow instead of white?
- ☐ Swelling, drainage, or encrusted matter

CoyÔSlYs: Report if child acts like something is wrong with their vision.

- ☐ Child is overly sensitive to bright light/sun
- ☐ Child has burning, itchy, or teary eyes
- ☐ Child often rubs or rapidly blinks (not when tired)?
- ☐ Appears to only see an object when separated from other items (e.g., can't find a toy if it is mixed with other toys)

Family history of vision loss? ☐ Yes ☐ No
Sibling/parent needed vision correction before age 5? ☐ Yes ☐ No
Other vision concerns? ☐ Yes ☐ No

Behaviors: Report how your child uses vision in daily tasks.

DOES YOUR CHILD?

Regard your face?	☐ Yes ☐ No
Squint or blink in bright light?	☐ Yes ☐ No
Stare at objects or people?	☐ Yes ☐ No
Smile in response to another person smiling (social smile)?	☐ Yes ☐ No
Track or follow objects for 180°?	☐ Yes ☐ No
Regard their own hands?	☐ Yes ☐ No
Make good eye contact?	☐ Yes ☐ No
Recognize people only after also hearing them speak?	☐ Yes ☐ No
Close their eyes or turn their face away when listening to others talk?	☐ Yes ☐ No
Hold an object very close to their eyes when looking at it?	☐ Yes ☐ No
Cover/close one eye to look at something in close range (less than 2 ft)?	☐ Yes ☐ No
Frown or squint when looking at something far away (more than 2 ft)?	☐ Yes ☐ No
Tilt/turn their head, tip their chin up/down, or thrust their head forward/backward to see?	☐ Yes ☐ No
Have trouble seeing small objects (e.g., a piece of cereal on a tray)?	☐ Yes ☐ No
Stare at lights for a long time?	☐ Yes ☐ No
Prefer certain colors over others (e.g., seek out items that are red)?	☐ Yes ☐ No
Have inconsistent vision from morning to night or in different environments?	☐ Yes ☐ No
Over- or under-reach for objects on the first try?	☐ Yes ☐ No
Look away while reaching for an object?	☐ Yes ☐ No
Stumble over objects or bump into walls?	☐ Yes ☐ No
Have trouble detecting a change in flooring, or miss steps/curbs?	☐ Yes ☐ No

Notes:

Vision Summary		☐ **PASS** ☐ **REFER** ☐ **REFER TO USDB-PIP** ☐ **INCONCLUSIVE**	
Assessment	**Date**	**Provider**	**Results**
Ophthalmology exam			
USDB vision evaluation			
Spot vision screener			