UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention Program

Initial 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:

Child Medical History

Routine prenatal care? ☐ **Yes** ☐ **No** **Maternal Fetal Medicine care?** ☐ **Yes** ☐ **No**
Prenatal exposure to alcohol/smoking/meds/drugs/toxic substances? ☐ **Yes** ☐ **No**
At birth: ☐ **Stable** ☐ **Unstable** **# Days in NICU:**
If premature/NICU: ☐ **ECMO** ☐ **ROP** ☐ **Oxygen** ☐ **Vent** ☐ **Jaundice** ☐ **Abx**
Other Events: ☐ **Hospitalization** ☐ **Surgery** ☐ **Injury** ☐ **ER visit**

Family Medical History

☐ Autism ☐ ADHD ☐ Developmental delay
☐ Postpartum depression, depression or anxiety
☐ Trauma or diagnosed mental health conditions
☐ Other childhood or genetic conditions
Are you or anyone who knows your child concerned about autism, or do you have any other concerns?

Notes:

Growth		PCTL/BMI
Birth Weight		
Birth Length		
Current Weight		
Current Length		

Concerns and Resources
Concerns about weight gain? ☐ Yes ☐ No
Adequate access to food? ☐ Yes ☐ No
WIC services? ☐ Yes ☐ No
Special diet? ☐ Yes ☐ No

Immunization Status

☐ Current for age
☐ Not current but plans to get current
☐ Modified schedule
☐ Does not immunize

Does your child have reflux? ☐ Yes ☐ No Has swallow study been done? ☐ Yes ☐ No

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

Notes:

Feeding/Nutrition

☐ 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

Mealtime Routines

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:

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Social-Emotional Wellness		Sleep Routines		Neurological
□ Calm alert state	□ Irritable	□ Reg bedtime?	Bedtime:	□ Sz □ TBI □ IVH □ PKU □ CVA
□ Easy to comfort	□ Hard to calm	□ Sleeps all night	Wake time:	□ Brain/spinal cord malformation
□ 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	

Notes:

Respiratory	Cardiovascular	Musculoskeletal
□ WNL □ On O2 □ Trach □ Apnea	□ WNL □ Brady/Tachy □ Murmur	□ Normal gait □ Good ROM
□ Uses SVN □ Chronic cough/wheezing	□ ASD/VSD □ PDA □ CCHD	□ Torticollis □ Hypotonic □ Hypertonic

Notes:

Mouth/Dental	HEENT	Skin	GI/GU
□ WNL □ Teething □ Excessive drooling	□ WNL □ Atypical head shape	□ WNL □ Sensitive	□ WNL
□ Cleft lip/palate □ Tongue/lip tie	□ Ear tags/pits	□ Eczema □ Rash	□ Normal genitalia
Has your child seen a dentist?	□ Atypical ear formation/position	□ Hives □ Birthmarks	# stools/day:
Do they have dental caries?	□ Atypical eye formation/position	□ Edema □ Pale	# wet diapers/day:
Do you brush their teeth?	□ Adenopathy	□ Jaundice	
How often?			

Notes:

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Health Summary

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

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

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?		
Startle/cry after a loud noise?	☐ Yes	☐ No
Calm down/smile/turn toward a familiar voice?	☐ Yes	☐ No
Have different cries for different needs?	☐ Yes	☐ No
Like toys that make noise?	☐ Yes	☐ No
Seem sensitive to certain noises?	☐ Yes	☐ No
Follow simple commands?	☐ Yes	☐ No
Respond to their name?	☐ Yes	☐ No
Respond to a whisper?	☐ 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

Initial 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

Complaints: 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			