15 MONTH WELL CHILD EXAM

NAME: Bortner Kassidy	VISIT DATE: 5/4/00	DOB: 2/4/99
I.D. #: (Medicaid/Ins) 67216061A	Physician: ID #: 661088	Actual Age: 15 Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	(Nl)	Ab
2. Illnesses/Injuries	(Nl)	Ab
3. Stools/urine	(Nl)	Ab
4. Diet	(Nl)	Ab
5. Feeding problems	Y	(N)
breastfeeding ____ x/day		
milk ____ oz/day		
meals ____ x/day		
wean to a cup — sleeps ok		
6. Vitamins	Nl	Ab
7. Fluoride (water, Rx)	Y	N
8. Family nutrition, balanced	Nl	Ab
9. Family status	Nl	Ab
10. Smoke free environment	(Y)	N
11. Child care plans	Y	N

(2) PHYSICAL EXAM

	Nl	Ab
12. WT 23.10 75 %	✓	
13. HT 33½ 95 %	✓	
14. WT/HT ____ %	✓	
15. HC 46½ 50 %	✓	
16. Skin	✓	
17. Head	✓	
18. Eyes	✓	
19. Hearing	✓	
20. Ears [TM] — ymes	✓	
21. Throat-nose	✓	
22. Teeth (caries, bbtd) — (sympth)	✓	
23. Neck	✓	
24. Lungs	✓	
25. Heart, pulses	✓	
26. Abdomen	✓	
27. Genitalia	✓	
28. Musc/Skel	✓	
29. Gait	✓	
30. Neuro	✓	
31. Extremities	✓	
32. General hygiene	✓	

(3) IMMUNIZATIONS GIVEN

	Y	N
33. (HIB # 3 or # 4)		
34. (DTP/DtaP # 4)		
35. Hep B # 3		
36. (MMR)		
37. Varicella		
38. Other ____		
39. Up to date? — no		✓

(5) DEVELOPMENTAL MILESTONES

	Y	N
42. Vocabulary 3 - 6 + words	✓	
43. Listens to story	✓	
44. Points to one or more body parts	✓	
45. Gestures what they want	✓	
46. Understands simple commands	✓	
47. Walks, stoops, climbs stairs	✓	
48. Stacks blocks — 5yom	✓	
49. Feeds self with fingers	✓	
50. Drinks from a cup	✓	
51. Social play	✓	

Hosp/Surg: Ø, meds: Ø, All: Ø

(4) SCREENING

40. Blood lead test (if not previously done) Blood lead test if on Medicaid, WIC, etc. or at risk:	(Nl)	Ab
• lives in pre-1960 housing	Y	N
• lives in pre-1978 housing with renovations within 6 months	Y	N
• lead poisoned sibling/playmate	Y	N
41. Do PPD (if exposure risk)	Y	N
If done, result	Neg	Pos

(6) KEY ANTICIPATORY GUIDANCE

√ * = key items

- *52. Supervise constantly near hazards
- *53. Offer variety of nutritious foods
- *54. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
- 55. Toddler car seat in back
- *56. Caution around animals
- 57. Test smoke detectors
- 58. Keep home/car smokefree
- 59. Avoid balloons/small/sharp objects
- 60. Ensure water/playground safety
- 61. Sun exposure/sunscreen
- 62. Ipecac, Poison Control #
- 63. CPR training
- 64. Encourage cup drinking
- 65. Encourage self-feeding
- 66. Avoid choking/risk foods
- 67. Brush teeth will little or no toothpaste
- 68. Keep bedtime routines
- 69. Praise good behavior
- 70. Read, sing, play together
- 71. Stove/fireplace safety
- 72. Childcare/Daycare
- 73. No punitive toilet training

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN | **EPSDT only: Child needs assistance for follow up for testing/treatment** Y N

WCA. Ø Meds. Eats + sleeps good. Ø problems.

Dtap⁴ MMR' HIB⁴ — well child UTD

PHYSICAL SIGNATURE: [signature] RTC in 3 months DATE: 5/9/00

DISTRIBUTION: Original is Provider's copy Yellow is EPSDT copy BF19 0698

18 MONTH WELL CHILD EXAM

NAME: Bortner, Kassidy **VISIT DATE:** 8/10/00 **DOB:** 2/4/99

I.D. #: (Medicaid/Ins) 672160601A **Physician: ID #:** G. Glass Adrienne Platt **Actual Age:** 18 Months

KEY: Mark Nl if normal, Ab if abnormal, or Y if yes, N if no, or ✓, if item done

(1) HISTORY

1. General health	Nl ✓	Ab
2. Illnesses	Y	N ✓
3. Sleeping/nap	Y ✓	N
4. Feeding	Nl ✓	Ab
breastfeeding ________ x/day	Y	N
milk ________ /day (24oz /day)		
5. Balanced diet	Y ✓	N
6. Vitamins/supplements/Fe	Y	N
7. Fluoride Pure Capi	Y	N
8. Stools	Nl ✓	Ab
9. Urine	Nl ✓	Ab
10. Family status	Nl ✓	Ab
11. Smoke free environment	Y ✓	N
12. Child care plans	Y ✓	N

NKDA

(2) PHYSICAL EXAM

	Nl	Ab
13. WT 23 3/2, 50 %		
14. HT 34 1/2, 100 %		
15. HC 47 1/4, 60 %		
16. Skin		
17. Head, fontanel		
18. Eyes		
19. Hearing		
20. Ears [TM], Throat, Nose		
21 Teeth decay		
22. Neck		
23. Lungs		
24. Heart, pulses		
25. Abdomen		
26. Genitalia		
27. Musc/Skel		
28. Gait (circled) toeing in		
29. Neuro		
30. Extremities		
31. General hygiene		

(3) IMMUNIZATIONS GIVEN

if not done	Y	N
32. Hep B # 3		
33. Varicella		
34. IPV # 3		
35. OPV # 3		
36. DTaP , DTP # 4		
37. Up to date?		

(5) DEVELOPMENTAL MILESTONES

	Y	N
40 Confident walk	✓	
41. Walk backwards	✓	
42. Throw ball	✓	
43. Vocab 15-20 words	✓	
44. Imitates words	✓	
45. 2-word phrases	✓	
46. Stacks 3 or 4 blocks	✓	
47. Uses spoon and cup	✓	
48. Shows affection	✓	
49. Follows simple directions	✓	
50. Scribbles	✓	
51. Points to some body parts	✓	
52. Can remove clothing	✓	

turns feet inward

(4) SCREENING

	Y	N
38. If no previous lead test done, Blood lead test if on Medicaid, WIC, etc., or at risk:	Y	N
• lives in pre-1960 housing	Y	N
• lives in pre-1978 housing with renovations within 6 months	Y	N
• lead poisoned sibling/playmate	Y	N
39. Do PPD (if exposure risk)	Y	N
If done, result	Neg	Pos

(6) KEY ANTICIPATORY GUIDANCE

✓ * = Key items

- ✓ *53. Child oriented routines
- ✓ *54. Never leave child alone in car/home
- ✓ 55. Smoke detectors
- ✓ 56. Keep home/car smoke-free
- ✓ 57. Toddler car seat in back
- 58. Ensure water/playground safety
- ✓ 59. Supervise constantly near hazards
- ✓ 60. Cautions about pets
- 61. Sun exposure/sunscreen
- ✓ 62. Child proof home: poisons, matches, meds, alcohol, outlets, stairway gates, window guards
- 63. Ipecac, Poison Control #
- 64. Encourage self-feeding, cup use
- 65. Avoid choking/risk foods
- 66. Eat with family, highchair/booster
- 67. Snacks low in sugar
- 68. Continue teeth brushing
- 69. Read, sing, talk with child
- 70. Help them express feelings
- 71. Model appropriate language
- 72. Anger/temper tantrums
- 73. Nightmares, night awakenings, fears
- 74. Consistent limits/praise good behavior
- 75. Ask about Medicaid/WIC

ASSESSMENT/ABNORMALS (Use reference numbers) PLAN | **EPSDT only: Child needs assistance for follow up for testing/treatment** Y N

NKA to meds. Ø meds currently
all solids. Whole milk 4-8 oz cups a day
1 nap 2 1/2 hrs afternoon

Hx of rt fem... is daily ... to

(refusal to orthotics)

WRT ... under finger

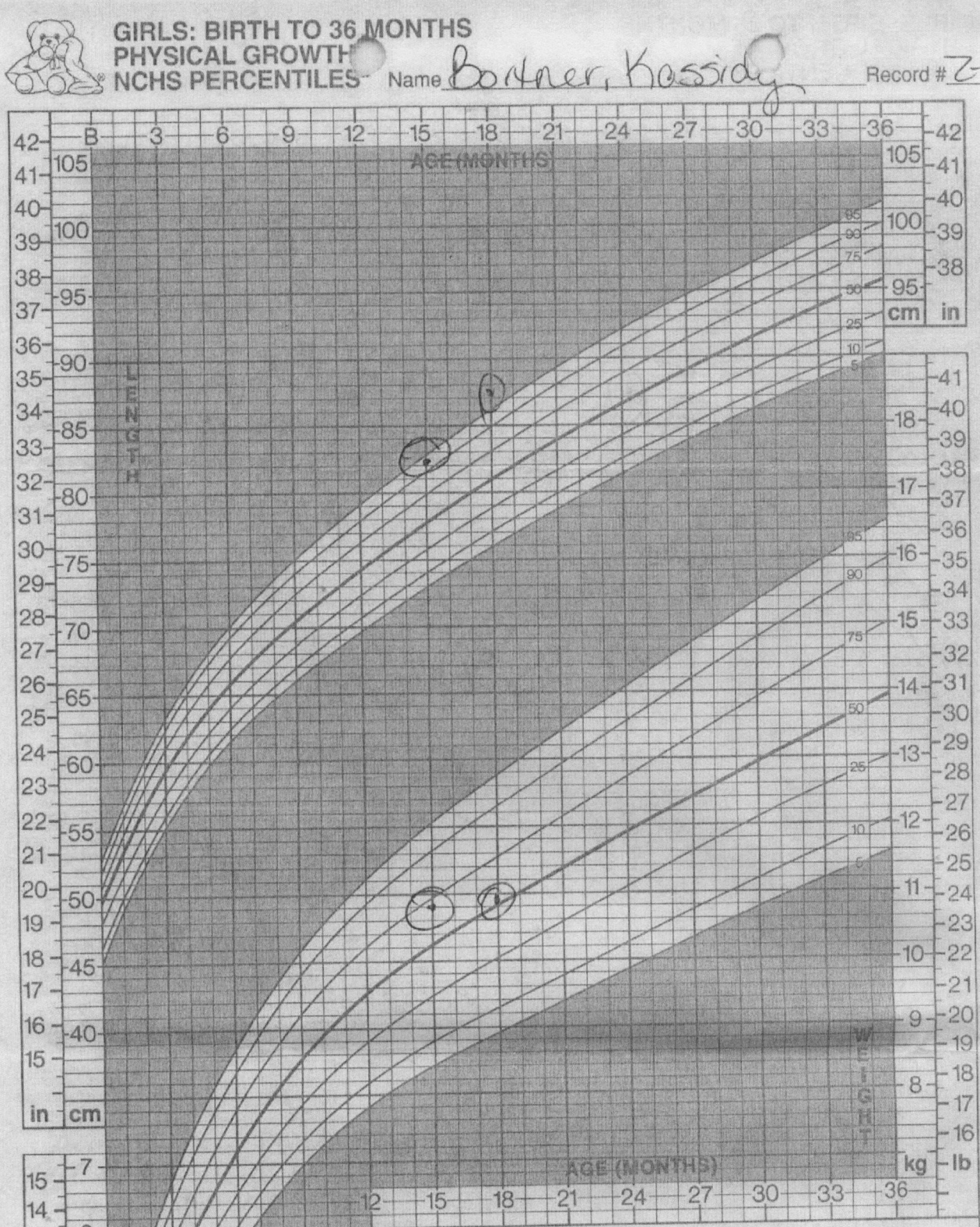
at home mom, a... grandma
2 brothers

PHYSICIAN SIGNATURE: [signature] **RTC in** 6 **months** **DATE:** 8/10/00

DISTRIBUTION: Original is Provider's copy Yellow is EPSDT copy BF19 0698

GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

Name Bortner, Kassidy Record # Z-4-99



MOTHER'S STATURE _____ GESTATIONAL AGE _____ WEEKS

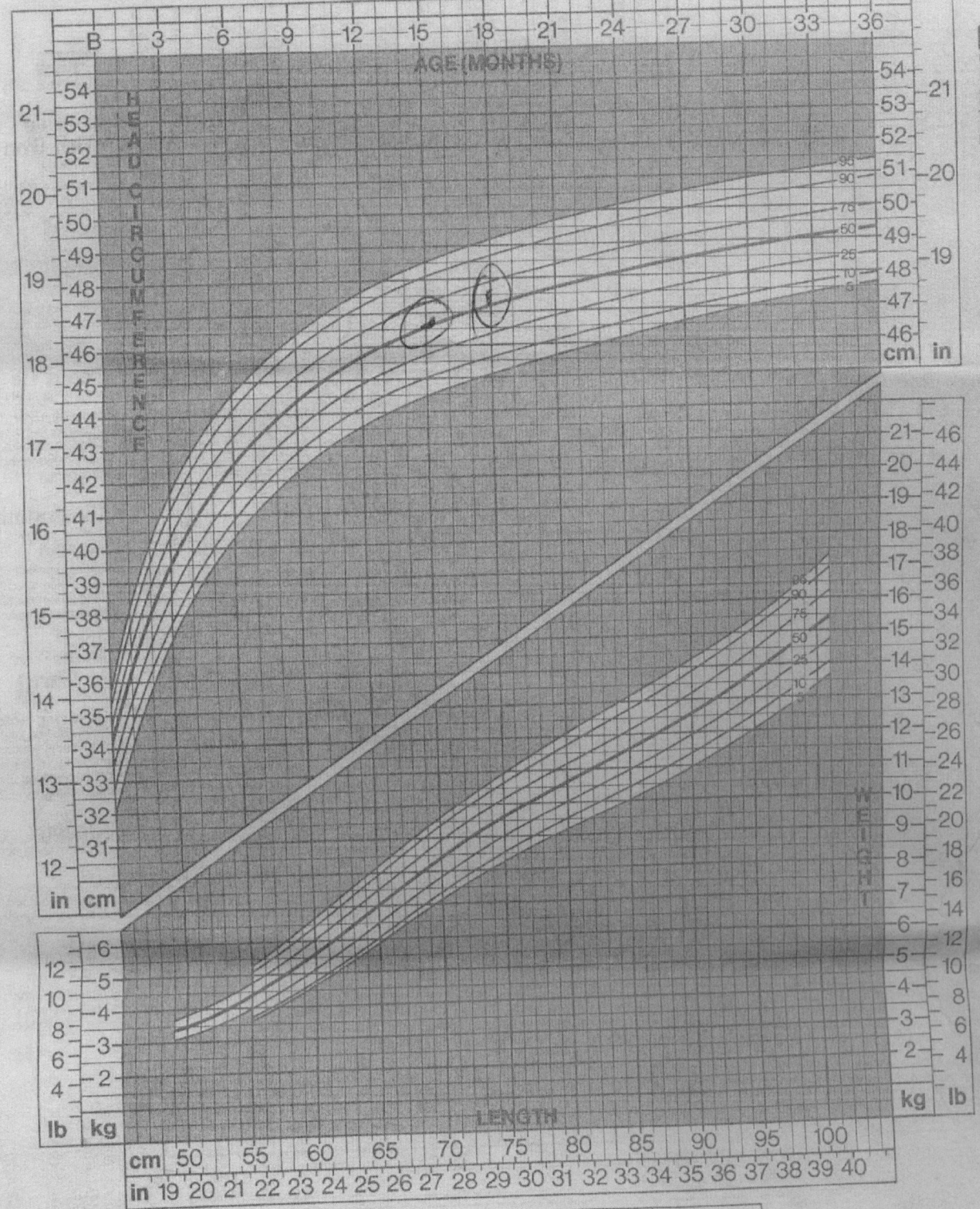
FATHER'S STATURE _____

DATE	AGE	LENGTH	WEIGHT	HEAD CIRC.	COMMENT
	BIRTH				
8/10/00	18m	34½	23 3½	47¼	

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Longitudinal Study, Wright State University School of Medicine, Yellow Springs, Ohio.

GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

Name _____ Record # _____



DATE	AGE	LENGTH	WEIGHT	HEAD CIRC.	COMMENT

Pediatric Associates
185 Webster Street
Lewiston, Maine 04240
(207) 784-5782

PATIENT Bortner, Kassidy D.O.B. 2/4/99

Vaccine Administration Record

" I have read, or have had explained to me information about the diseases and the vaccines listed below. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named below for whom I am authorized to make this request."

VACCINE	Date Given	Vaccine Manufacturer	Vaccine Lot Number	Site Given	Initials of Vaccine Administrator*	Signature of Parent or Guardian
DTP 1						
DTP 2						
DTP 3						
DTP/DTaP 4	5/9/00	SK	91982	RAT	mR	Amanda Bortner
DTP/DTaP 5						
OPV/IPV 1						
OPV/IPV 2						
OPV/IPV 3						
OPV/IPV 4						
MMR 1	5/9/00	MSD		LA	mR	Amanda Bortner
MMR 2						
Hib 1	~~8/10~~					
Hib 2						
Hib 4	8/10/00	Merck	0874J	RA	AB	*Amanda Bortner
Hib 3	5/9/00	MERCK	08745	RA	mR	Amanda Bortner
DT						
Td						
Hep B 1						
Hep B 2						
Hep B 3						
Varivax	~~8/10~~ 8/10/00	Merck	16885	LA	AB	*Amanda Bortner
MONO-VACC						
MONO-VACC						

*Signature of Vaccine Administrator

mR Mary Ann Roy LPN

Use reverse side if more signatures are needed.

Pediatric Associates

PROBLEM LIST

NAME Bortner, Kassidy DOB 2-4-99

CHRONIC PROBLEMS	THERAPY

ACUTE PROBLEMS	DATES						

Department of Human Services
HealthWorks
P.O. Box 709
Augusta, ME 04332-0709
1-800-977-6740
or (207) 621-2300
Fax # : (207) 621-2332
Medicaid Voice Response: 800-452-4694
Medicaid Inquiry: 800-321-5557

State of Maine

Maine PrimeCare Referral Form

FAXED 8/18/00

(Type or print clearly all information/multiple copies)

1. PATIENT INFORMATION: KASSidy (First Name) Bortner (Last Name)

Medicaid ID# 6721606 1A (Use Medicaid # only) Date of Birth 2-4-99 (MM/DD/YYYY)

2. REFERRAL TO:

Name JAMES TIMONEY

Address 2 GREAT FALLS PLAZA Auburn, ME

Telephone # 783-1328 ~~783-9000~~ 795-1397 Appointment Date/Time 9-11-00 (MM/DD/YYYY 00:00AM/PM)

3. TYPE OF REFERRAL: (Check all that apply)

- ☐ Single consultation visit for opinion
- ☒ Treatment up to 3 visits (If not specified, three visits will be authorized)
- ☐ No diagnostic procedures
- ☐ Single visit for treatment
- ☐ No lab, x-ray
- ☒ Valid for 6 months (If not specified, this referral will be valid for six months)
- ☐ Surgery/Admit
- ☐ Therapy: OT ___ PT ___ SP ___
- ☒ Other, please explain in box #4.

4. CLINICAL INFORMATION:

Reason for referral

Toeing in

5. REFERRAL AUTHORIZATION: (Authorization # must match PCP/PCPS of record. Authorized signature may be PCP or designated personnel at site)

Primary Care Provider/Site (Name) PEDIATRIC ASSOCIATES

Authorized Signature George Glass

Authorization Number 00020400 7 (HCFA1500=Block 17a/UB92=Block 11) Date 8-16-00 (MM/DD/YY)

*This referral is not a guarantee:

A. That the service is a covered Medicaid service;

B. That the patient will be eligible for Medicaid at the time of service; or

C. That the service has received Prior Authorization from the Department. Prior Authorization is required for certain surgical procedures, durable medical equipment (DME) and all out-of-state services - 800-321-5557 ext 72033.

WHITE - HealthWorks **YELLOW** - Referral Provider **PINK** - PCP/PCPS **GOLD** - Patient

Pediatric Associates of Lewiston
REFERRAL FORM

783-1328 Date: 8-

Name: Kassidy Bartner

D.O.B: 2-4-99

Referral To: Cath

Diagnosis: Laryngo

Patient needs to be seen within:
Stat:(same day)____
ASAP: (within 1-2 weeks)____
Whenever Available:____
Prefers:____

Consulting Physicain____

Timoney Mon Sept 11 @ 3: