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Introduction

Texas Health Steps

The *Texas Medicaid Provider Procedures Manual - Texas Health Steps* (formerly the *Texas Medicaid Service Delivery Guide*) is provided as the guide to Medicaid Texas Health Steps (THSteps) providers. Its purpose is to give health and health-related providers information about Medicaid THSteps medical and dental policies, key public health department contacts, suggested forms for chart documentation, and cross-references to the *Texas Medicaid Provider Procedures Manual*.

The information in the *Texas Medicaid Provider Procedures Manual - Texas Health Steps* at times duplicates information in the *Texas Medicaid Provider Procedures Manual* to ensure providers and billing and coding personnel have the same reference material. However, most of the information in the two volumes is different because of the intended audiences; therefore, the two volumes generally are meant to be complementary.

Additionally, users of both volumes are encouraged to read the bimonthly *Texas Medicaid Bulletin*, which includes timely updates on new and revised medical and dental policies, as well as educational, billing, and coding information.

As certain service delivery areas are managed care and others are fee-for-service, it is critical for readers to understand that reimbursement methods and plans may vary. Thus, providers and administrative personnel will find detailed information of the Medicaid program in the above-referenced publications. However, if providers are serving Medicaid-eligible individuals who are enrolled in a State of Texas Access Reform (STAR) Medicaid Managed Care Organization (MCO), then it is important for them to check the MCO's Provider Manual for more information about billing and contractual requirements within each plan.

Medicaid Program Administration

Effective January 1, 2004, the new Texas Medicaid Claims and Primary Care Case Management (PCCM) Administrator is Affiliated Computer Services (ACS). ACS will be referred to as the Texas Medicaid & Healthcare Partnership (TMHP) in this and future Medicaid publications.

The Texas Department of Human Services (TDHS) is responsible for determining client eligibility. Eligibility policy is established by a TDHS central office in Austin, Texas. Eligibility determinations are made at local TDHS offices. The local TDHS offices are administered through regional offices throughout the state.

Refer to: "Communication Guide" on page A-1 of the *2004 Texas Provider Procedures Manual* for addresses and telephone numbers of the Texas Health and Human Services Commission (HHSC) and TDHS regional offices.

Section

1

Medical Transportation Program

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1.1 Medical Transportation

The Medical Transportation Program (MTP) is funded with federal and state funds to provide eligible clients and their attendants nonemergency transportation. When eligible clients and their attendants have no other means of transportation, the Texas Department of Health (TDH) arranges the most cost-effective mode of transportation to and from a medically necessary health care facility that can meet the client's medical needs, including dental services for clients younger than age 21.

1.1.1 MTP Eligibility

People who are currently eligible for regular Medicaid, Texas Indigent Cancer Patients, or Children with Special Health Care Needs (CSHCN) are eligible to receive services. The client's attending physician must certify the need for an attendant unless the client is a CSHCN client, a minor, or when a language or other barrier to communication or mobility exists that require the assistance of an attendant. For Medicaid and CSHCN clients under age 21, MTP will provide advance funds for travel. Additionally, when health care services requires an eligible client to remain overnight, MTP will provide for meals and lodging for the eligible child and attendant. CSHCN clients over 21 diagnosed with cystic fibrosis may also qualify for these services.

1.1.2 MTP Requirements

Services are available to eligible clients and their attendants who have no other means of transportation to health care facilities to receive medically necessary health program services for which federal financial participation (FFP) is available. In some cases, the client's attending physician will be asked to complete Form 3113, Health Care Provider Statement of Need. Form 3113 is required to determine if a particular health care service is medically necessary, FFP is available, and that there is not a 'reasonably close' health care provider.

1.1.3 Contacting the MTP

Clients or their advocates should call the statewide MTP toll-free number, 877-633-8747, to request transportation services. For transportation services within the county, or a county adjacent to the resident county, the client or his or her advocate should call the MTP office at least two workdays before the scheduled appointment. For clients who need to travel

beyond an adjacent county, the client or his or her advocate should call the MTP office at least five workdays before the scheduled appointment. The following client information must be provided to the intake operator at the time of the call:

- Medicaid number, CSHCN number, or Social Security number
- Name, address, and telephone number, if available
- Name, address, and telephone number of the health care provider
- Purpose of the trip
- Affirmation that no other means of transportation is available
- Special needs, wheelchair lift, or attendant need

1.1.4 MTP Program Limitations

Clients and their attendants are **not** eligible to receive medical transportation services under the following circumstances (this list is not all-inclusive):

- Transportation by emergency or nonemergency ambulance service
- Transportation of a client who is younger than age 18 years and not accompanied by a parent or legal guardian, unless one of the following conditions exist:
  - The client is age 15 through 17 years and presents the parent's or legal guardian's signed, written consent for the transportation services to the Regional MTP office or the transportation contractor
  - The treatment to which the minor is being transported is such that the law extends confidentiality to the minor for this treatment
- Transportation to or from a day activity health services facility, personal care home, state institution, nursing facility (unless the client requires dialysis treatment), or a facility participating in another Title XIX program whose rate structure includes transportation funds
- Transportation when the client or another person or entity providing care for the client receives direct payment of worker's compensation benefits, U.S. Department of Veteran Affairs benefits, or other third party resources for transportation to health care services on the client's behalf
- Transportation when the client is an inpatient in a health care facility
- Transportation of a deceased client
- Passenger assistance beyond that which is necessary to ensure that a client can enter and leave vehicle safely unless the contractor's contract states that door-to-door service is provided

Refer to: Title 25, Part 1, Chapter 40 of the Texas Administrative Code (TAC) for more information.

Section

2

Texas Health Steps (THSteps)

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THSteps Medical

The Medicaid service, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), is known in Texas as Texas Health Steps (THSteps).

2.1 Administrative Information

2.1.1 Enrollment

Providers cannot be enrolled if their professional license is due to expire within 30 days of application.

Note: If no claims are submitted for 12 months from an existing provider with a Texas Provider Identifier (TPI) number, the 9-character TPI will be deactivated. Providers must complete a full application to reactivate their TPI. Providers will only be notified of this deactivation through denied claims on their *Remittance and Status (R&S)* report.

Refer to: "Provider Enrollment and Responsibilities" on page 2-1 in the *Texas Medicaid Provider Procedures Manual* for more information about enrollment procedures.

For STAR Program Enrollment, THSteps providers must enroll with each STAR and STAR+PLUS health plan to be reimbursed for services provided to STAR and STAR+PLUS program members.

2.1.1.1 Provider Types

To enroll independently in the Texas Medicaid and THSteps medical program, providers must be:

- Physicians (MD, DO) currently licensed in the state where the service is provided.
- Health care providers of facilities (public or private) capable of performing the required medical checkup procedures under the direction of a physician, such as regional and local health departments, family planning clinics, migrant health clinics, community-based hospitals and clinics, maternity clinics, rural health clinics, home health agencies, school districts, and family or pediatric nurse practitioners. In the case of a clinic, a physician does not have to be present in the clinic at all times during the hours of operation; however, a physician must assume responsibility for the clinic's operation.
- A family and pediatric nurse practitioner.
- A certified nurse-midwife, as a provider of THSteps medical checkups for adolescent females and newborns up to two months of age.
- A women's health care nurse practitioner, as a provider of THSteps medical checkups for adolescent females.
- An adult nurse practitioner, as a provider of THSteps checkups for adolescents older than age 14 years.

The unclothed physical examination must be completed by one of the following:

- A physician
- Family or pediatric nurse practitioner
- Certified nurse-midwife (newborn to two months of age and adolescent females)
- Adult nurse practitioner (people older than age 14)
- Women's health nurse practitioner (adolescent females)
- A registered nurse (RN) or licensed physician assistant (PA) may only perform under a physician's supervision. The physician ensures that the RN or PA has appropriate training and adequate skills to perform the procedures for which he or she is responsible.

2.1.1.2 Additional Education Requirements for Registered Nurses (RNs)

TDH requires all RNs performing THSteps medical checkups to receive additional education training in comprehensive pediatric assessment. To qualify for conducting a THSteps physical examination, RNs must have completed, after graduation from nursing school, courses in pediatric assessment that include the following components:

- Unclothed physical examination
- Developmental/mental health assessment
- Nutritional assessment
- Anticipatory guidance

This training may be obtained through either credit hours at an accredited college or university, or through approved Continuing Education Unit (CEU) courses.

If the pediatric course did not include a formal preceptorship (observation of the individual's skills over a period of time), the RN should receive personal supervision by a physician (or family/pediatric nurse practitioners) until the physician (or family/pediatric nurse practitioners) determines the RN to be competent in performing these functions. Documentation of special training should be included in the employee's personnel file.

The Texas Nurses Association (TNA) offers two approved courses:

- *Basic Concepts in Identifying the Health Needs of Adolescents:* This course offers approved CEUs and CPEs through TNA and concentrates on the assessment of the adolescent. The curriculum is composed of state-of-the-art interdisciplinary core content in adolescent health developed by experts in the field. Participants for this course include the following:
  - Physician assistants
  - Nurse practitioners
  - Registered nurses
  - Social workers
  - Nutritionists
  - Dietitians
- *Comprehensive Pediatric Assessment:* A clinical preceptorship with a physician or advanced practice nurse (APN) as part of this training includes the following topics:
  - THSteps
  - Family medical history, pediatric physical assessment
  - Nutritional, developmental, and mental assessments
  - Case management
  - Anticipatory guidance

Other courses containing the same components are acceptable.

It is recommended that PAs have expertise and/or additional education in the areas of comprehensive pediatric assessment. The course offered by TNA also is available for PAs and provides CEUs for PAs as well as RNs.

Call TNA at 512-452-0645 or visit www.thsteps.org for more information and enrollment for either *Basic Concepts in Identifying the Health Needs of Adolescents* or *Comprehensive Pediatric Assessment*.

2.1.2 Eligibility for Medical Checkups

Providers are encouraged to perform checkups on any client identified as eligible for medical checkups. They are encouraged also to notify the client when he or she is due for the next medical checkup according to the periodicity schedule.

As part of Chapter 31, Human Resources Code, *Vernon's Texas Codes Annotated*, Temporary Assistance for Needy Families (TANF) clients risk a financial penalty for each child who is not current with THSteps medical checkups and immunizations. Clients do not lose Medicaid eligibility for failure to get medical checkups or immunizations. Medicaid clients who do not receive TANF financial benefits are not subject to penalty.

The client is periodically eligible for medical checkup services based on the American Academy of Pediatrics (AAP) Periodicity Schedule. A check mark on the Medicaid Identification (Form 3087) indicates eligibility for the particular service (eye exam, eye glasses, hearing aid, ICF-MR dental, prescriptions, and medical services). A blank space denotes that the client is not periodically eligible for the particular service based on available data. A THSteps statement under the client's name on the regular Medicaid Identification Form and the STAR Identification Form (3087 STAR) indicates the THSteps services for which the client is currently eligible. Checkups provided when a THSteps statement does not indicate that a medical checkup is due are exceptions to the periodicity schedule.

Providers who question the accuracy of the current information on the client's Medicaid Identification (Form 3087) are encouraged to check the client's eligibility by calling TMHP Contact Center at 800-925-9126 or use TMHP Provider Web Site to check the client's eligibility file.

Although the Medicaid Eligibility Verification Form (1027) identifies eligible clients when the Medicaid Identification (Form 3087) is lost or has not yet been issued, this form does not indicate periodic eligibility for medical checkup services. Providers should call the TMHP Customer Service at 800-925-9126 or check TMHP Provider Portal to verify a client's periodic eligibility for medical checkup services.

Refer to: "Client Eligibility" on page 1-1 of the *Texas Medicaid Provider Procedures Manual*.
"Vision Care (Optometrists, Opticians)" on page 42-1 of the *Texas Medicaid Provider Procedures Manual*.

2.1.2.1 Newborn Eligibility

A newborn child is eligible for Medicaid for up to one year from date of birth if all the following conditions are met:

- The mother is receiving Medicaid at the time of the child's birth.
- The mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant.
- The child is living with the mother.

If the newborn has Medicaid coverage, it is **not** acceptable for a provider to require a deposit for newborn care from a parent/guardian. The child's Medicaid eligibility stops if the mother relinquishes her parental rights or it is determined that the child is no longer part of the mother's household.

If a hospital or birthing center notifies TDHS about the newborn child born to a mother eligible for Medicaid, the hospital caseworker, mother, and attending physician (if identified) should receive an interim notice from TDHS a few weeks after the child's birth that includes the child's Medicaid number and effective date of coverage. After the child has been added to the TDHS eligibility file, a Medicaid Identification (Form 3087) is issued.

The Medicaid number on the interim notice (Form 1027) may be used to identify newborns eligible for Medicaid for purposes of THSteps medical checkups.

Note: Claims submitted for services provided to a newborn eligible for Medicaid must be filed using the newborn child's Medicaid number.

2.1.3 Claim Forms

THSteps medical checkups may be billed electronically or by submitting a HCFA-1500 claim form. Providers may purchase the HCFA-1500 claim form from the vendor of their choice; TMHP does not supply the forms. For billing questions, call TMHP Customer Service at 800-925-9126.

2.1.4 Facilities for THSteps Medical Checkup

All THSteps medical checkup policies apply to examinations completed in a physician's office, a health department, clinic setting, or mobile/satellite unit. Enrollment of a unit is under a physician or clinic name. Mobile units can be a van or any area away from the primary office and are considered extensions of that office.

For specific information, review the periodicity schedules and narrative explaining the schedules. The physical setting must be appropriate so that all elements of the medical checkup can be completed.

2.1.4.1 Medical Home Concept

TDH encourages providers participating in the Texas Medicaid Program to practice the "medical home concept" for clients with Medicaid. To realize the maximum benefit of health care, each family and individual needs to be a participating member of a readily identifiable, community-based medical home. The medical home provides primary medical care and preventive health services and is the individual's and family's initial contact point when accessing health care. It is a partnership among the individual and family, health care providers within the medical home, and extended network of consultative and specialty providers with whom the medical home has an ongoing and collaborative relationship. The providers in the medical home are knowledgeable about the individual's and family's specialty care and health-related social and educational needs and are connected with necessary resources in the community that will assist the family in meeting those needs.

When referring for consultation, specialty/hospital services, health and health-related services, the medical home maintains the primary relationship with the individual and family, keeps abreast of the current status of the individual and family through a planned feedback mechanism, and accepts them back into the medical home for continuing primary medical care and preventive health services. To ensure that medical care for children is available and coordinated, TDH encourages medical checkups to be provided by the medical home.

Refer to: "Managed Care" on page F-1 of the *Texas Medicaid Provider Procedures Manual* for information about freedom of choice and referrals for providers in areas of the state covered by Medicaid Managed Care.

2.1.4.2 Continuity of Care and the Medical Home

The individual providing the medical checkup must ask the parents if the child has a private physician or a medical home where the child usually receives medical care.

If the children's medical home is providing THSteps checkups, it is in the children's and family's best interest for providers to encourage that relationship. If the family has a medical home but prefers to have their checkup done by another provider, that provider should send a copy of the THSteps medical checkup records examinations to the primary care provider.

If the medical checkup provider is unable to offer a medical home to the children, that provider must enter into written agreements with providers who are willing to offer medical homes.

2.1.4.3 Mobile Units

In the case of a provider who has mobile units functioning in different communities, the agreements must be signed in each community so that children are referred to local providers for medical homes.

Mobile providers must advise the family that they have freedom of choice concerning who completes the medical checkups.

2.1.5 Referrals for Medicaid Covered Services

When a provider performing a checkup determines that a referral for diagnosis and treatment is necessary for a condition found during the medical checkup, that information must be discussed with the parents. The referral should be made to a provider who is qualified to perform the necessary diagnosis and treatment services. Effort should be made to maintain continuity of care.

If the provider performing the medical checkup can provide treatment for the condition identified, a separate claim (HCFA-1500 or UB-92) must be submitted for the same date of service as the checkup with an appropriate office visit for the diagnosis and treatment of the identified problem.

It is important that follow-up contacts are made to ensure that the children keep appointments when a referral is made. Files should not be closed until the provider knows that the appointment was kept and a tentative diagnosis for the referral is on file. In addition to referrals for problems discovered during a checkup or for specialized care, the following referrals may be used:

- Routine Dental Referrals – Routine dental referrals are to be made on all children at age 1 and every 6 months thereafter through age 20 (see "THSteps Dental" on page 47). Children younger than age 1 are not eligible for **routine** dental services. However, children younger than age 1 should be referred when a medical checkup identifies the medical necessity for dental services. **Clients up to age 21 may also self-refer for dental care.**
- Emergency Dental Referrals – If a medical checkup provider identifies an emergency need for dental services, such as bleeding, infection, or excessive pain, the client may be referred directly to a participating dental provider. Emergency dental services are covered at any time for all THSteps clients eligible for Medicaid up to age 21.

Note: In cases of both emergency or nonemergency dental services, clients have freedom of choice in selecting a dental provider who is participating in the THSteps Dental Program.

- Family Planning and Genetic Services Referrals – For people eligible for Medicaid needing genetic services or family planning services, a referral should be made. Information on Medicaid-covered genetic services and family planning services is available in the Genetics and Family Planning Agency sections of the *Texas Medicaid Provider Procedures Manual*. If the screening provider also provides family planning, the provider may inform the client of availability of these services.
- THSteps-Comprehensive Care Program (CCP) Services Referrals – CCP benefits are medically necessary services for which federal financial participation (FFP) is available and may be services currently not covered under the Texas Medicaid State Plan (e.g., orthotics, private duty nursing, and others), as well as expanded coverage of current services that have limitations.
- See"Hearing Screening" on page 17 for referrals following a hearing screening.

Refer to: "Managed Care" on page F-1 of the *Texas Medicaid Provider Procedures Manual* for more information on referrals for providers in areas of the state covered by Medicaid Managed Care.
"THSteps-Comprehensive Care Program (THSteps-CCP)" on page 40-20 of the *Texas Medicaid Provider Procedures Manual* for CCP service requirements (client eligibility, prior authorization, and provider participation).

2.1.6 Statutory Requirements

Several specific legislative requirements affect the THSteps Program and the providers participating in the program. These include, but are not limited to, the following:

- Newborn Blood Screening, Health and Safety Code, Chapter 33, *Vernon's Texas Codes Annotated*
- Parental Accompaniment, Human Resources Code, §32.024, *Vernon's Texas Codes Annotated*
- Requirements for Reporting Abuse or Neglect. Providers are required to comply with Family Code Sec. 261.101, *Vernon's Texas Codes Annotated.*
- Simplified Enrollment, Human Resources Code, §32.025, *Vernon's Texas Codes Annotated*
- Early Childhood Intervention (ECI), 34 CFR Part 303; Chapter 73, Human Resources Code, *Vernon's Texas Codes Annotated,* and 25 TAC Chapter 621

Refer to: "Statutory Requirements" on page 99 for more information.

2.1.7 Verification of Medical Checkups

The first source of verification that a THSteps medical checkup has occurred is a paid claim or encounter. THSteps encourages providers to file a claim either electronically or on a HCFA-1500 claim form, as soon as possible, after the date of service.

The second source of acceptable verification is a physician's written statement that the checkup occurred. If the provider chooses to give the client written verification, it must include the child's name, Medicaid ID number, date of the medical checkup, and a notation that a complete THSteps medical checkup was performed.

If neither the first nor the second source of verification is available, a THSteps staff member may contact your office for verification.

Refer to: "Communication Directory" on page 85 for contact information.
"Communication Guide" on page A-1 of the *Texas Medicaid Provider Procedures Manual.*

2.2 Clinical Information

2.2.1 Medical Checkup Periodicity Schedule

The THSteps schedule is based on the Recommendations for Preventive Pediatric Health Care of the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics. In Texas, the THSteps Program has modified the AAP periodicity schedule based on the scheduling of a test in federal EPSDT regulations or other programs, or to meet the population's needs.

The current version includes the annual checkups for adolescents in this single periodicity schedule to emphasize the AAP recommendation that comprehensive checkups be performed annually. The provider is encouraged to emphasize the anticipatory guidance educational components based on risk assessment.

All components of the THSteps medical checkup are included in the reimbursement for the visit. The visit is a comprehensive medical checkup and must include all assessments, screenings, and laboratory tests as indicated on the periodicity schedule. Specifically, when there is an available CPT code for a component, it will not be reimbursed separately on the same day as a medical checkup.

2.2.1.1 THSteps Medical Checkups Periodicity Schedule for Infants and Children

THSteps Medical Checkups Periodicity Schedule for Infants and Children (Birth through 9 Years)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical checkup. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age.

	INFANCY/EARLY CHILDHOOD									MIDDLE CHILDHOOD					
	Weeks		Months							Years					
Age [1]	Inpatient	2	2	4	6	9	12	15	18	2	3	4	5	6	8
History															
Family	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Neonatal	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		
Physical, Mental Health, Developmental	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical Examination [2]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements															
Height/Weight/BMI	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●					
B/P											●	●	●	●	●
Nutrition	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Mental Health		●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screening															
Vision Screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tuberculin Screening [3]							✚	✔	✔	✚	✚	✚	✚	✚	✚
Laboratory [4]															
Newborn Hereditary [5] Metabolic Testing	●	●	✔	✔	✔	✔	✔								
Hgb or Hct [6]					●	✔	●	✔	✔	●	✔	✔	✔	●	✔
Lead Screening [7]					✚	✔	●	✔	✔	●	✚	✚	✚	✚	
Hemoglobin Type [8]	●	●	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Cholesterol [9]										✚	✚	✚	✚	✚	✚
Immunizations [10]	●	✔	●	●	●	✔	●	✔	✔	✔	✔	●	✔	✔	✔
Dental Referral [11]							●	✔	✔	●	●	●	●	●	●
Anticipatory Guidance [12]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY

- ● Required, unless medically contraindicated or against parental religious beliefs.
- ✔ Required as above, unless already provided on a previous checkup at the required age and documented on the health record with the date of service.
- ✚ If answers on high risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to footnotes for more information on items marked ✚.

FOOTNOTES

1. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up to date as soon as possible.
2. A complete unclothed physical exam is required at each checkup. Older children are to be appropriately draped.
3. In areas of low prevalence, administer the TB questionnaire annually beginning at 1 year. In areas of high prevalence, administer the TB skin test at one year and once between 4 years through 6 years. Administer the TB questionnaire annually beginning at age 2 and thereafter at other visits.
4. Clients are not to be referred to a laboratory for completion of service. All blood specimens are to be submitted to the TDH clinical chemistry lab for analysis.
5. Newborn screening (hereditary/metabolic testing [hypothyroidism, PKU, galactosemia, sickle Hgb, CAH]) is required by Texas law before hospital discharge and again between 1 and 2 weeks old. Date and results of second newborn screening are to be documented. Patients are not to be referred to the local health department for testing.
6. Hgb and Hct, done at a WIC clinic or in a provider's office, is acceptable within one month if date and value are documented.
7. Mandatory blood screens at 12 and 24 months. Questionnaire acceptable at other visits. Refer to "Lead Screening" in Appendix D of the *Texas Medicaid Provider Procedures Manual - Texas Health Steps.*
8. If Hgb type has been performed previously and results are documented in chart, it does not need to be repeated. Hgb type also is part of the newborn screening.
9. Screen for risks of increased levels of cholesterol (no formal questionnaire provided by THSteps).
10. Clients are not to be referred to the local health department for immunization. Vaccines must be obtained from the Texas Vaccines for Children Program at TDH. TDH requires that immunizations be administered at the time of the checkup. See "Section 4" Immunizations Overview, for exclusions from immunizations.
11. Dental referrals are required for all patients beginning at age 1. Patients are eligible for preventive dental checkups every 6 months thereafter.
12. Counseling/anticipatory guidance is a required integral part of each visit and must be face to face with the child's parent or guardian.

2.2.1.2 THSteps Medical Checkups Periodicity Schedule for Adolescents

THSteps Medical Checkups Periodicity Schedule for Adolescents (10 through 20 Years)

The columns across the top of the schedule indicate the age a client is periodically eligible for a medical checkup. The first column on the left of the chart identifies each procedure that must be performed at each appropriate age.

Age [1]	CHILDHOOD				ADOLESENCE						
	10	11	12	13	14	15	16	17	18	19	20
History											
Family	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Physical, Mental Health, Developmental	●	●	●	●	●	●	●	●	●	●	●
Behavioral Risks [2]	●	●	●	●	●	●	●	●	●	●	●
Physical Examination [3]	●	●	●	●	●	●	●	●	●	●	●
Measurements											
Height/Weight/BMI	●	●	●	●	●	●	●	●	●	●	●
B/P	●	●	●	●	●	●	●	●	●	●	●
Nutrition	●	●	●	●	●	●	●	●	●	●	●
Mental Health Assessment	●	●	●	●	●	●	●	●	●	●	●
Sensory Screening											
Vision Screening	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●	●	●	●	●	●	●	●	●	●	●
Tuberculin Screening [4]	●	●	●	●	●	●	●	●	●	●	●
Laboratory											
Hgb or Hct [5]	✔	✔	●	✔	✔	✔	●	✔	✔	✔	✔
Hemoglobin Type [6]	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
STD Screening [7]		✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Pap Smear			✚	✚	✚	✚	✚	✚	●	●	●
Cholesterol [8]	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚	✚
Immunizations [9]	✔	✔	✔	●	●	✔	✔	✔	✔	✔	✔
Dental Referral [10]	●	●	●	●	●	●	●	●	●	●	●
Anticipatory Guidance [11]	●	●	●	●	●	●	●	●	●	●	●

KEY

- ● Required, unless medically contraindicated or against parental religious beliefs.
- ✔ Required as above, unless already provided on a previous checkup at the required age and documented on the health record with the date of service.
- ✚ If patient responses on risk assessment questionnaires or other screening show a risk factor, further screening is required. Refer to footnotes for more information on items marked ✚.

FOOTNOTES

1. If a child comes under care for the first time at any point on the schedule or if any procedures are not accomplished at the appropriate age, the client must be brought up to date as soon as possible.
2. Screening for adolescent lifestyle risk factors is to include eating disorders, sexual activity, alcohol, (and other drug use), tobacco use, school performance, depressions, and risk of suicide.
3. A complete unclothed physical exam is required at each visit with client appropriately draped.
4. In areas of low prevalence, administer the tuberculin questionnaire annually beginning at 1 year. In areas of high prevalence, administer the skin test between 11 years through 16 years; administer the questionnaire annually at other visits.
5. Hgb and Hct, (if pregnant or breast feeding) done at a WIC clinic is acceptable within one month if date and value are documented.
6. If Hgb type has been performed and results previously documented in patient's chart, it does not need to be repeated. (Hgb type is part of the newborn screening.)
7. For sexually active or high-risk adolescents, screening is to include, Pap smears for cervical cancer, evaluation for genital warts, cultures for gonorrhea and chlamydia, and blood test for syphilis and HIV. While all adolescents should be screened for the risk of HIV infection, actual testing is voluntary and requires the consent of client. Refer to Section 5 of the *Texas Medicaid Provider Procedures Manual - Texas Health Steps* for more information on HIV screening and to the Adolescent Screening section for information concerning STD.
8. Screen for risks of increased levels of cholesterol (no formal questionnaire provided by THSteps).
9. Clients are not to be referred to the local health department for immunization. Vaccines must be obtained from the Texas Vaccines for Children Program at TDH. Refer to the *Texas Medicaid Provider Procedures Manual - Texas Health Steps* for information for vaccines for 19 through 20 years of age. TDH requires that immunizations be administered at the time of the checkup. See "Section 4" Immunizations Overview, for exclusions from immunizations.
10. Dental referrals are required for all patients. Patients are eligible for preventive dental checkups every 6 months.
11. Counseling/anticipatory guidance is a required integral part of each checkup and must be face-to-face. For adolescents, health guidance should include parenting, development, diet, physical activity, healthy lifestyles and injury prevention, including information concerning high-risk behavior identified during the checkup. See Section 2 of the *Texas Medicaid Provider Procedures Manual - Texas Health Steps* for further information.

2.2.2 Medical Checkups for Infants and Children (Ages Birth – 9 Years)

The following information lists descriptions and standards for each pediatric assessment and test that must be performed during a THSteps medical checkup in accordance with the periodicity schedule.

Refer to: "Medical Checkup Periodicity Schedule" on page 10.

2.2.2.1 History

The child's initial history must include the following:

- Family medical history
- Neonatal history
- Physical and mental health history
- Developmental history
- Immunization history
- History of feeding or nutrition problems
- A complete review of body systems

Subsequent histories may be specific for the child's age and health history.

The history must be obtained from an adult caregiver familiar with the child and the child's health history.

2.2.2.2 Physical

A complete physical examination is required at each visit with infants totally unclothed and older children undressed and suitably draped. The physical examination must include assessment of the following systems:

- Skin
- Head, eyes, ears, nose, and throat (HEENT)
- Dental
- Heart
- Chest/lungs (includes breast exam for females past menarche)
- Abdomen (including hernia)
- Skeletal
- Neurological (includes evaluation of cerebral, cranial nerve, and cerebellar functions, motor and sensory systems, and reflexes)
- Genitalia (includes observation for appropriate sexual development)

2.2.2.3 Measurements

The physical examination must include the following measurements:

- Length, for children approximately birth–2 years
- Height, for children approximately 3–20 years
- Weight, for children birth–20 years
- Body Mass Index (BMI), for children 2–20 years
- Head circumference, frontal-occipital circumference, for children younger than age 2
- Blood pressure (for children age 3 and older, use the appropriate cuff size)

The aforementioned requirements for measurements other than blood pressure are to be compared to the National Center for Health Statistics growth charts to identify significant deviations from norms. These charts can be ordered from the TDH warehouse.

The aforementioned requirements for measurements of blood pressure should be compared to Appendix I in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, National M&CH Clearinghouse, 8201 Greensboro Drive, Ste. 600, McLean, VA 22102) or *Guidelines for Health Supervision II* from the American Academy of Pediatrics Publication Department, PO Box 927, 141 Northwest Point Blvd., Elkgrove Village IL 60009-0927 for more information.

Refer to: "Child Health Clinical Records" on page 109 for more information.

2.2.2.4 Nutritional Assessment

The nutritional assessment is to be accomplished during the basic examination using the following methods:

- Questions about dietary practices to identify unusual eating habits (such as pica or extended use of bottle feedings) or diets that are deficient or excessive in one or more food groups
- Quality and quantity determination of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs like women, infants, and children [WIC])
- A complete physical examination, including an oral dental examination, paying special attention to general features, such as pallor, apathy, and irritability
- Accurate height and weight measurements and calculation of BMI as important indices of nutritional status
- Laboratory screenings for anemia (hemoglobin, hematocrit, erythrocyte protoporphyrin [EP]), as indicated

2.2.2.5 Developmental Assessment

Physicians. Developmental assessment is to be accomplished at each medical checkup based on the physician's personal preference of tests or review of developmental milestones with an adult caregiver familiar with the child. It is recommended that at least the following elements be included in the assessment:

- Gross motor development, focusing on strength, balance, locomotion
- Fine motor development, focusing on eye-hand coordination (includes vision screening)
- Communication skills/speech-language development, focusing on expression, comprehension, and speech articulation (includes hearing screening)
- Self-help and self-care skills
- Social-emotional development, focusing on the ability to engage in social interaction with other children or adolescents, parents, and other adults
- Cognitive skills, focusing on problem-solving or reasoning, observation, and school progress
- Mental health

Physicians are not required to perform formal developmental screening. It is advised that they consider following the procedures for the "nonphysicians" as described in the following paragraph.

Requirements for Developmental Screening by Nonphysicians. Nonphysicians conducting THSteps medical checkups on children ages birth to 6 years are required to conduct a standardized observational developmental screen for a child:

- Between the ages of 9–12 months
- Between ages 18–24 months

- Between ages 24 months to 6 years if the child does not have a record of a standardized observational developmental screen
- When a parent expresses concern about the child's developmental progress

The nonphysician must use a standardized parent questionnaire at all other periodic visits up to and including the 6th year.

Nonphysicians may perform the screen at other ages at the provider's discretion.

The combined use of a questionnaire reflects the child's developmental status more accurately than a single observational screen. If parents are unable to read or understand the questionnaire, the provider should use the parent questionnaire in an interview format. If the child fails the parent questionnaire, follow the instructions of the tool concerning either observation testing or referral.

Children age 7 years and older should be screened by observation, history of school progress, and neurological assessment.

Choice and Use of Tools. A standardized tool is one that has been extensively evaluated through screening thousands of children and comparing the screen outcome of each individual child with the outcome of an in-depth developmental evaluation on that child.

If the screening tool specifies that training is required to use the tool, the screener must complete this training.

Referrals for Developmental Assessment. Referral for an in-depth developmental evaluation is determined by the criteria of the specific tool. The screener should understand and follow them. Referral for in-depth evaluation of development should be provided when parents express concern about their child's development, regardless of scoring on standardized development screening tool.

Referrals for indepth evaluation of development must be made to an Early Childhood Intervention (ECI) program (ages birth through 3 years) for suspected delay, as required by state law. The provider also may refer to a pediatrician with skill in developmental assessment or the school district (ages 3 years and older).

Refer to: "Statutory Requirements" on page 99 for more information.

2.2.2.6 Mental Health

Guidelines for Mental Health Screening. Ideally, the mental health screen is part of every comprehensive well-child checkup. The age-specific interview tools and parent questionnaires are provided as an option for performing this screen. They are intended for use as part of a comprehensive pediatric assessment. If these interview tools are used outside the context of a comprehensive examination, the interviewer must remember to collect information usually gathered in a pediatric history: household members, prenatal/newborn history, child's health history, and family illnesses.

The purpose of the mental health screen is to identify problems in any of six domains: feelings, behavior, social interactions, thinking, physical problems, and other problems that may include substance abuse. The provider choosing alternative screening tools or techniques should be certain to screen in these domains. Screening may reveal several minor problems or one or more significant problems that warrant referral for, or provision of, evaluation and, if indicated, treatment. In determining whether behaviors are serious enough to warrant referral, the screener must weigh the extent and intensity of the problems and explore the child's resiliency and positive behaviors. If the child has been or is under treatment for any mental health conditions, record that treatment in the child's medical record.

Referral options may include parenting education programs, ECI programs (ages birth to 3), mental health evaluation and counseling, substance abuse programs, acute psychiatric hospitalization, or child protective services. The screener's responsibility is to identify and establish a referral relationship with these resources in the community.

Screeners with special training and credentials allowing evaluation and treatment of childhood behavior problems, mental illness, or substance abuse may choose to provide these services rather than referring. Other screeners should refer to mental health specialists.

Confidentiality. The screener introduces the screen by explaining that the information provided will be held in strictest confidence unless the screener recognizes a situation that places the child or others in danger.

Children older than age 4 years should not be present when the screener questions the parent regarding possible abuse or neglect.

Beginning at about age 10 years, questions about peer and family social interaction and substance abuse are explored with the child and parent separately. All parts of the screen are administered to the adolescent and his or her parent/caregiver separately.

If observations of the child, the parent, or parent-child interaction lead the screener to suspect possible abuse or neglect, the screener must make a report to Child Protective Services. The report is required even though the screener may refer a family for evaluation or treatment of abuse/neglect.

Behavior of particular concern. Behavior generally expressive of mental health problems include those listed below. If the screener finds any of the following significant behaviors, further screening is unnecessary because referral is indicated:

- Setting fires
- Suicidal behavior or ideation
- Self-destructive activities
- Torturing animals
- Hurting other people
- Destroying property
- Loss of touch with reality
- Inappropriate sexual behavior
- Substance abuse
- Parental concern about their ability to maintain the child in the home

Important: At the conclusion of a screening that is judged by the provider to be within regular limits, the screener should refer the child for a comprehensive mental health evaluation if the parent of older child remains concerned that the child has mental health or behavior problems.

Interview Tools/Referral Forms. The interview tools found on pages 132–154 contain age-specific questions to guide the provider. Items of concern should be circled. Extensive notes may have to be made on a separate sheet. A copy of this form may be used as a referral form.

The parent questionnaire is similar to the interview tool. It is advisable in the first visit to explain and administer the interview face-to-face. At subsequent visits, the age-appropriate form may be given to a literate parent or adolescent with the instruction, “Circle any of these items that you feel are a problem for your child/you and that you would like to discuss with your provider.”

2.2.2.7 Sensory Screening

Vision Screening. Children of all ages must have their vision screened as part of the THSteps medical checkup. Testing must be appropriate to the child’s age, ability, and cooperation level.

Newborns. At the initial test at birth, the provider should do the following:

- Check for “red reflex”
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others), or family history of vision or eye problems

Birth through age 2 years. The provider should do the following:

- Collect observation and history from a caregiver
- Check for "red reflex"
- Determine whether pupils equally react to light
- Screen for heterophoria with the corneal light reflex and cover test for children older than six months
- Note history for high-risk conditions, such as congenital infections (rubella, herpes, and others), or family history of vision or eye problems

At ages 3 through 4 years. The provider should do the following:

- Administer tumbling E or H:O:T:V: test or equivalent at each 3 and 4 year visit
- Screen through the 20/20 line
- Determine whether child reads more than half of the 20/40 line or four out of six H:O:T:V: symbols
- Screen for heterophoria with the corneal light reflex and cover test or Random Dot E
- Refer children with two-line difference between the two eyes
- Document and complete the test as described for birth to 2 years if a 3-year-old is unable to cooperate

For children ages 5 and older. The provider should do the following:

- Evaluate with letter chart or Tumbling E chart at ages 5-10 years, 12, 15, and 18 years
- Refer if unable to read majority of 20/30 line or four out of six H:O:T:V: symbols
- Evaluate whether less than 4 of 6 are correct
- Administer cover test or Random Dot E

Vision screening supplies. Vision screening supplies can be ordered from the following vendors:

School Health
865 Muirfield Drive
Hanover Park IL 60103
800-323-1305

Snellen Letter
"Tumbling E" Wall Charts
Prevent Blindness Texas
3211 West Dallas
Houston TX 77019
713-526-2559

Universal Ophthalmic Instruments, Inc.
8902 FM 2920
281-320-7550

Vision Testing Equipment
Good-lite Company
PO Box 387
Streamwood IL 60107-0387
630-529-9720
800-362-3860

Wilson Ophthalmic
PO Box 496
Mustang OK 73064
800-222-2020

Hearing Screening.

Newborn Hearing Screening. Health and Safety Code, Chapter 47, *Vernon's Texas Codes Annotated* states that the hearing screening must occur at the birthing facility before the newborn is discharged from the hospital. The hospital is responsible for the purchase of equipment, training of personnel, screening of the newborns, certification of the program in accordance with TDH standards, and notification to the provider, parents, and TDH of screening results. There is no additional Medicaid reimbursement for the hearing screening as the procedure is part of the newborn DRG. Hospitals should use the ICD-9-CM procedure code 09547, Hearing examination, not otherwise specified, to report this newborn hearing screen.

This facility-based screening also meets the physician's required component for hearing screening in the inpatient newborn THSteps checkup. The physician must ensure that hearing screening is completed before discharging the newborn or, when the birthing facility is exempt under the law, there is an appropriate referral for hearing screening to a birthing facility participating in the newborn hearing screening program.

The physician should discuss the screening results with the parents, especially if the hearing screening results are abnormal, and should order an appropriate referral for further diagnostic testing. If the results are abnormal, parent/legal guardian consent must be obtained to send information to TDH for tracking and follow-up purposes.

If a physician has any concerns about this process, contact the hospital administrator or the TDH Audiology Services program at 512-458-7724.

Initial test at birth. The provider should do the following:

- Verify that the parents received the results of the hearing screen at the birthing facility
- Check for obvious physical abnormalities
- Supply hearing checklist for parents and instruct on its use (this checklist should be discussed at the first in-office THSteps medical checkup)
- Provide a referral for further diagnostic audiological testing for an infant with abnormal screening results or who is at high-risk for hearing impairment

Outpatient Hearing Screening and Diagnostic Testing for Children. As part of the THSteps medical checkups, physicians are required to complete the hearing screening component. Separate procedure codes should not be billed when hearing screenings are part of medical checkups or day care/school requirements. Medicaid will not reimburse separately.

For children who are seen in the office setting, the THSteps program requires a puretone audiometer at visits where objective screening is required. In other child-care settings, (e.g., day care; preschool; Head Start; elementary, middle, and high school), the TDH Vision and Hearing Screening Program requires that a puretone audiometer be used for hearing screening.

Impedance testing usually is used in the physician's office to monitor children who have a documented history of repeated bouts of otitis media and may be billed separately as a diagnostic hearing test with a THSteps checkup. Impedance testing does not meet the requirements for the sensory screening component of the THSteps checkup as described on pages 17 and 19.

Birth through age 3. The provider should do the following:

- Observe and record history from a responsible adult familiar with the child using the Hearing Checklist for Parents
- Refer high-risk children for further audiological diagnostic testing

At age 4 and older. The provider should do the following:

- Assess children with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) at ages 4-10 years
- Perform a subjective hearing evaluation to include client history and observation of the child for the ability to answer questions and follow directions at all other medical checkups where an audiometric screen is not required
- Document the results of a school screening audiometric testing program, which may be used in place of testing in the office if within 12 months of the checkup
- Refer any child in preschool or kindergarten who does not respond to a 25B tone at any frequency, or any child/adolescent in 1st through 12th grade or older who does not respond to a 20 dB tone at any frequency

The following codes will be denied if claimed on the same day as a medical checkup:

CPT Code	Description
92531	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold), air only

Hearing Referrals. For all age groups, refer children identified during the THSteps medical checkup as needing a diagnostic hearing evaluation or other hearing services, including hearing aids, to an approved hearing services provider. TDH provides payment for services rendered by these providers to children eligible for Medicaid and younger than age 21. Hearing exams and services, including hearing aids (**prior authorization needed**), are available when medically necessary. Payment for these services for clients who are Medicaid-eligible and younger than age 21 are made through TDH's Program for Amplification for Children of Texas (PACT). An appropriate hearing screening is a mandatory part of each medical checkup.

Separate procedure codes may be billed for children who require diagnostic hearing testing. The following diagnostic audiometric testing codes may be billed as appropriate:

Procedure Code	Description
92567	Tympanometry (Impedance Testing)
92585	Auditory Brainstem Response (ABR) Testing
92586	ABR, limited
92587	Limited Otoacoustic Emissions
92588	Comprehensive Otoacoustic Emissions

2.2.2.8 Tuberculosis Screening

The periodicity schedule for tuberculin tests is in accordance with federal Centers for Disease Control and Prevention (CDC) guidelines. THSteps requires a form of TB screening at every annual visit, as noted on the periodicity schedule. A questionnaire has been developed to determine if the child or adolescent is at high-risk for tuberculosis and needs Mantoux skin testing. This questionnaire and guideline material was developed by the TDH TB Elimination Division and follows current CDC guidelines.

Note: Including a code on the claim form for a completed TB Risk Questionnaire is no longer necessary. While the provider may choose to retain the questionnaire, the provider must document the screening, any risk factors identified, and any appropriate follow-up.

Important: "Live virus vaccines can interfere with response to a tuberculin test (TB). TB Testing, if otherwise indicated, can be performed either on the same day that the live virus vaccines are administered or no sooner than 4 to 6 weeks later." MMWR Vol. 43 #RR 1 p. 15.

Tuberculin tests are to be performed in the provider's office or clinic. The materials (PPD-Mantoux antigen and syringe) are distributed free of charge to the provider upon the request of the local or regional health departments. The cost of administering the test is included in the medical checkup fee. If a follow-up medical checkup visit is required to check a **presumptive positive reaction**, the provider may bill the follow-up medical checkup fee of $6. TINE testing materials are **not** supplied by TDH and should not be used.

Diagnosis and treatment are provided as a Medicaid office visit.

In accordance with the recommendations of the TDH TB Elimination Division, the THSteps Program requires the following:

- Providers should contact their local or regional health department to determine if their service area is a high-prevalence area for TB. A listing of counties with a high prevalence for TB also may be found at www.tdh.state.tx.us/tb/hiprev.htm.

In areas of low prevalence:

- Administer the TB Risk Questionnaire beginning at age 1 year and annually thereafter. TB skin testing should be done if the questionnaire indicates a risk factor or if the provider determines that a skin test is appropriate.

In areas of high prevalence:

- TB skin testing should be administered at age 1, once between ages 4 and 6, and once between ages 11 and 16. If the client refuses the skin test or the child is uncooperative, administer the questionnaire. The questionnaire should be administered annually beginning at age 2 years and thereafter at all other visits. In those age ranges where a skin test is recommended, the provider should administer the TB skin test at one of these ages and the questionnaire at the other annual checkups.
- The TB skin test should also be administered at these ages if a risk factor is indicated or if the provider determines a skin test is appropriate.
- Children whose medical checkup is an exception to periodicity due to placement in foster care should receive a TB skin test at that visit.

Refer to: "Guidelines: Tuberculosis Skin Testing (2 Pages)" on page 157.

Positive Skin Tests. Any newly identified positive reactions should be evaluated by a screening provider or referred for evaluation. Report any suspected cases or diagnosed cases of tuberculosis to your local health department.

Refer to: Pages 157 through 162 for more information on TB screening and follow-up of skin test results.

2.2.2.9 Immunizations

Children must be immunized during THSteps medical checkups according to the Recommended Childhood Immunization Schedule for the United States, as shown on page 58. The checkup provider is responsible for the administration of immunizations and must not refer children to local health departments or other entities. TDH requires that immunizations be administered during the THSteps medical checkup unless medically contraindicated or excluded from immunizations for reasons of conscience, including a religious belief.

A $5 administration fee per dose is paid for immunizations given during a THSteps medical checkup or as part of a follow-up visit. THSteps providers should bill for each vaccine separately. If administering a combined vaccine such as diphtheria, tetanus, and pertussis vaccines (DTaP), do not bill separately for each antigen.

The Texas Vaccines for Children Program (TVFC) provides vaccines for children who receive services under THSteps that are routinely recommended according to the Recommended Childhood Immunization Schedule (Advisory Committee on Immunization Practices [ACIP], American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP]).

Refer to: "Immunizations" on page J-1 of the *Texas Medicaid Provider Procedures Manual* and "Immunizations" on page 55 of this manual for more information on enrolling as a TVFC provider.

Consent forms. Vaccine Information Statements are required by federal mandate to inform parents and vaccine recipients of the risks and benefits of the vaccine they are about to receive. Not only is it important to explain the risks and benefits before a vaccine is administered, but it is also important that providers use the most current forms available. For more information regarding immunizations, vaccine preventable diseases, or literature and forms, call the TDH Immunization Division at 800-252-9152.

2.2.2.10 Health Education/Anticipatory Guidance

Health education is a federally mandated component of the THSteps medical checkup and includes anticipatory guidance. Health education and counseling **face-to-face** with parent(s) or guardian(s) and children **is required** to assist parents in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, accident and disease prevention. Written material also may be given, but will not replace face-to-face counseling.

Age and developmentally appropriate health education, anticipatory guidance, and counseling includes the following:

- Developmental expectations
- Dental health
- Sleep
- Feeding and nutrition
- Elimination
- Lead poisoning risks
- Healthy lifestyle/practices
- Accident and disease prevention

Refer to: *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd edition, National M&CH Clearinghouse, 8201 Greensboro Drive, Ste. 600, McLean VA 22102) or *Guidelines for Health Supervision II* from the American Academy of Pediatrics Publication Department, PO Box 927, 141 Northwest Point Blvd., Elkgrove Village IL 60009-0927, for more information.

2.2.2.11 Dental Assessment

Dental Assessment Guidelines for THSteps Medical Providers. The following information provides guidelines for THSteps medical providers in performing the initial dental screening as required within a comprehensive THSteps medical checkup.

The applicable periodicity schedule for THSteps Dental Assessment follows the standards as adopted by the American Academy of Pediatric Dentistry. The oral screening by the medical provider, as required within the comprehensive THSteps medical checkup, should occur at all medical checkups. The medical checkup must initiate the referral for the more comprehensive THSteps Dental Exam by a THSteps participating dentist, starting at age 1 and every six months thereafter (unless unusual circumstances dictate more frequent referrals). Eruption pattern evaluation by the medical provider can be a valuable diagnostic tool. A delayed eruption pattern of 6 through 12 months should be evaluated by the medical provider for potential medical/nutrition etiology. An eruption pattern and sequence chart is provided in the "Development of Human Dentition Chart" on page 54.

Baby Bottle Tooth Decay (BBTD). To reduce the risk of Baby Bottle Tooth Decay (BBTD) the parent/guardian should always be counseled in proper feeding practices, including the following:

- Never put a child to bed with a bottle containing any liquid other than water
- Recommendations on the decreased frequency and duration of bottle feeding
- Bottle contents (water is recommended in the bottle other than at regular feeding times)
- Feedings should be followed by gentle cleansing of the oral structures with a clean, damp cloth or soft brush
- Establish goal to have the child drinking from a cup at 6 months of age

Early signs of BBTD often present as chalky white spots, particularly on the lingual surfaces of Maxillary incisors. These signs, or any indication of more advanced caries, should prompt an immediate referral to appropriate dental care providers for evaluation.

Primary Teeth. The 20 primary teeth are also called deciduous teeth or baby teeth. Besides functioning in mastication, they also serve roles in speech development, jaw development, and eventually in the position of the permanent dentition. Premature loss of the primary teeth can lead to permanent space loss within the dental arch and significant problems with alignment and function of the permanent teeth. If a primary tooth is lost prematurely, it is important for the patient to be evaluated within the next few weeks by a dentist, and a determination made for space supervision. Delayed exfoliation of the primary teeth may also have a harmful effect on the permanent dentition and calls for a dental evaluation.

Permanent Teeth. The first permanent tooth is the six-year molar, which is the sixth tooth from the mid-line between the central incisors. There are four of them, which erupt when a child is between ages 5 and 6. The first permanent molar is often mistaken for a primary tooth because no tooth is lost. These teeth are termed the keystones of the dental arches because they help guide the subsequent teeth into proper alignment.

Caries. Children with developing primary or mixed (primary-permanent) dentition should be evaluated for caries.

Oral Soft Tissues. Oral soft tissues should be examined for any abnormalities. Consultation with a dental provider, where a differential diagnosis may apply, is highly recommended.

Sealants. Many studies have shown that dental sealants can protect the tooth from decay when properly applied.

Patient Dental Education. This education should include the following:

- The need for thorough daily oral hygiene practices
- Education in potential gingival manifestations for patients with diabetes and patients under long-term medications therapy
- Utilization of the THSteps eligibility for dental services

Smokeless Tobacco. The use of smokeless tobacco is expanding in many population groups and is strongly correlated with an increase in the prevalence of oral cancer. Early intervention and education can play a significant role in reducing risks. The following steps should be taken:

- Assess patterns of use
- Offer assistance in cessation, if appropriate
- Evaluate oral hard and soft tissues particularly the muccobuccal folds, cheeks, and sublingual areas
- Refer all suspected lesions to appropriate providers for evaluation and follow-up

Referral Assistance. Assistance in coordinating the referral can be obtained from the TMHP Hotline (800-568-2460), or TDH Regional THSteps Coordinator for the respective region (lists provided in the "Communication Guide" on page A-1 of the *Texas Medicaid Provider Procedures Manual*).

Dental Disease Prevention. Perhaps the two most important interventions are:

- Early and periodic dental examinations
- Parent education that stresses to parents the important role they can play in preventing dental disease in their children

Regularly positioned teeth with normal occlusion add symmetry and harmony to the facial appearance and are an important aspect of the expression of emotion and personality.

THSteps Dental Services. THSteps dental services are mandated by Medicaid and provide reimbursement for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than age 21. THSteps dental service standards were designed to meet federal regulations and incorporate the recommendations of representatives of dental professional groups in the state.

Follow-up Dental Care and Referrals

If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnoses or treatment, the provider performing the dental checkup should assist the client in planning follow-up care or in making a referral to the qualified provider. The *Texas Medicaid Provider Procedures Manual* provides information regarding covered benefits, assistance to identify qualified providers, and coding and billing for services covered by the THSteps program, THSteps-CCP, or traditional Medicaid program. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available regardless of the limitations of the Texas Medicaid Program and is referred to as the Comprehensive Care Program (CCP).

Refer to: "THSteps-Comprehensive Care Program (THSteps-CCP)" on page 40-20 of the *Texas Medicaid Provider Procedures Manual* for more information.

2.2.2.12 Laboratory Procedures Screening Services

Important: All required laboratory work is to be performed by the TDH Bureau of Laboratories. TDH makes these services available free of charge to all enrolled THSteps medical checkup providers for THSteps eligible children. THSteps services provided in a private laboratory will not be reimbursed.

Note: Providers should make a request on the laboratory form if an extreme health problem exists and telephone results are needed quickly. With the exception of weekends and holidays, specimens are routinely analyzed within 36 hours after receipt by the TDH laboratory. The laboratory routinely contacts the submitter by telephone within one hour of confirmation of critical abnormal test results (e.g., hemoglobin equal to or below 7 g/dL, blood level ≥ 40 ug/dL).

THSteps laboratory specimens submitted to TDH must include the patient's name and Medicaid number as they appear on the Form 3087 on a THSteps Laboratory Request (Form NBS-3, G–1A, G-1B). Write PENDING in the Medicaid number space if a number is not currently available but is pending (i.e., a newborn or a newly certified patient verified by a Form 1027 as eligible for Medicaid).

Laboratory specimens received at TDH that do not have a Medicaid number or the word PENDING written in the nine-character space for the Medicaid number will be analyzed and the provider will be billed.

These services and supplies are limited to THSteps screening laboratory services provided in the course of a medical checkup to THSteps clients. Unauthorized use of services and supplies is in violation of federal regulations.

The $70.00 reimbursement for the complete medical checkup includes specimen collection, shipping, testing, and receiving test results from the TDH laboratory.

Claims for tests listed in the following table submitted by a provider or an outside laboratory for the same date of service as a THSteps medical checkup will be denied and are subject to retrospective review:

Procedure Code	Test
5-80061	Lipid panel
5-82465	Cholesterol, serum; total
5-83020	Hemoglobin electrophoresis
5-83655	Lead
5-83718	HDL cholesterol
5-84203	Protoporphyrin, RBC; screen
5-84478	Triglycerides
5-85018	Total hemoglobin

Procedure Code	Test
5-85014	Hematocrit
5-86403	Particle agglutination; screen, each antibody
5-86580	Skin test, tuberculosis, intradermal
5-86592	Syphilis; qualitative (e.g., VDRL, RPR, ART)
5-86689	HIV confirmation (Western blot)
5-86701	HIV-1
5-87490	Chlamydia (direct probe)
5-87590	Gonorrhea (direct probe)
5-88142	Pap smear
5-88147	Pap smear
5-88150	Pap smear
5-88164	Pap smear

Laboratory Supplies. Upon request, TDH provides the items listed below associated with blood specimen collection. All newly enrolled THSteps medical providers automatically receive a startup package of forms and supplies. Before startup packages are sent to providers, TDH Laboratories verifies enrollment of THSteps medical providers. A limited number of holders for venipuncture tubes (small and large) are supplied on request. The startup package includes:

- 2 mL vacuum tube (with anticoagulant) for venipuncture
- 1 mL capillary blood collector (with anticoagulant)
- 6 mL vacuum tube (without anticoagulant) for venipuncture (required for RPR)
- 22 gauge x 1 inch vacuum needle
- Lancets
- Laboratory Form G-1B
- *Get the Lead Out* handbook
- Mailing container with postage paid label (single- or multiple-tube)
- *Laboratory Screening Services* handbook

A written request for a newborn screening specimen collection form, NBS-3, and NBS supplies is required. To obtain an order form for written requests, call 512-458-7661.

All reorder requests for forms and supplies should be made using TDH Form G-399, which should be submitted to the following address:

TDH Bureau of Laboratories
1100 West 49th Street
Austin TX 78756-3199
512-458-7661

Supply requests can be faxed to the TDH laboratory at 512-458-7672. Providers should not order more than a three-month supply as most supplies have expiration dates and must be rotated frequently for efficient usage. To reduce waste in ordering, TDH monitors supply requests according to the number of specimens submitted by the provider. Keep unused tubes with anticoagulant in the original airtight self-closing plastic bag to prevent moisture and dust from reaching the anticoagulant.

Send Comments. If you have complaints or comments about THSteps specimen collection supplies, contact the TDH laboratory. Supplies are evaluated continually and comments from supply users are solicited. Documented comments may support or change an item in a state contract. Send a brief letter or fax to the following address:

Laboratory Services
TDH Bureau of Laboratories
1100 West 49th Street
Austin TX 78756-3199
Fax: 512-458-7672

Required Tests Listed in Alphabetical Order. The following laboratory screening procedures are a required component of the THSteps medical checkup and are to be performed in accordance with the age and frequency specified on the THSteps medical checkup periodicity schedule.

Hemoglobin or Hematocrit. Hemoglobin or hematocrit levels are required to indicate anemia resulting from poor diet or diseases. The required minimum frequency for hemoglobin or hematocrit testing is at ages 6 months, 12 months, 24 months, 6 years, 12 years, and 16 years. At 12 and 24 months, hemoglobin should be quantitated in conjunction with the lead screen. The laboratory request form must be marked for both hemoglobin and lead. Hemoglobin and hematocrit laboratory procedures performed at a WIC clinic or in a provider's office are acceptable if performed within one month and the date and value are documented.

The provider should note that the TDH laboratory uses the cyanmethemoglobin method to measure hemoglobin only.

Hemoglobin Type. If the hemoglobin type has been done, included as a part of newborn screening, and results are documented on the chart, it does not need to be repeated. It also may be performed at the provider's discretion as appropriate for age and population groups. For instance, certain children need this procedure to screen for sickle cell disease or trait.

The provider must note the following when checking for hemoglobinopathies:

- TDH uses isoelectric electrophoresis for initial screening. Confirmatory analysis (for HbS, HbC, HbE, HbO, and others) is made using isoelectric focusing or citrate agar electrophoresis as necessary. Cellulose acetate electrophoresis is used for quantitation of hemoglobin fractions.
- Quantitative figures are reported only if HbF is present in a patient older than age 1 or elevated A2 is detected (possible thalassemia).

Laboratory reports list the hemoglobin types detected. When definitive results are impossible, appropriate explanations are provided. Notes are entered if results are clinically significant.

Hyperlipidemia. Hyperlipidemia is based on risk assessment. THSteps does not provide a formal risk assessment tool. Providers may refer to the AAP policy statement on cholesterol screening for more information.

The cholesterol screen consists of a blood cholesterol level and patients do not need to fast before the screen. Specimens for lipid profiles should be from patients who have fasted at least 12 hours and are at-risk. A lipid profile includes the measurement of total blood cholesterol, triglycerides, and high-density lipoproteins (HDL), as well as calculated values for low-density liproteins (LDL).

Lead Screening. In accordance with current federal regulations, THSteps requires that children be screened for lead poisoning through either blood tests and/or questionnaires at ages 6, 12, 18, and 24 months, and annually until age 6.

Important: The abbreviated questionnaire may be used for children with a previously recorded normal blood lead level.

Lead screening involves actual blood lead analysis or completion of a parent questionnaire (with appropriate action taken depending on the answers) per current federal regulations. Blood lead analyses are mandatory at ages 12 and 24 months for THSteps clients. At other THSteps medical checkups (6 months, 18 months, 3, 4, 5, and 6 years), the parent questionnaire must be administered. If (at any age) the parent answers "yes" or "I don't know" to any of the questions, a blood

lead analysis is to be performed. Providers may copy the questionnaires from "THSteps Primary Parent Risk Assessment for Lead Exposure Questionnaire" on page 164 or order a maximum of 10 copies from TDH at 512-458-7745.

If the provider chooses not to use the parent questionnaire, he or she must continue to have blood lead testing performed at 6, 12, 18, and 24 months, and annually until age 6.

Providers may obtain more information about the medical and environmental management of lead poisoned children from the TDH Childhood Lead Poisoning Prevention Program by calling 800-588-1248.

Refer to: "Lead Screening Procedures and Follow Up" on page 93 for more information on follow-up guidelines and the Childhood Lead Poisoning Prevention Program, and resources available to providers who identify children with elevated blood lead levels.

Newborn Testing. Health and Safety Code, Chapter 33, *Vernon's Texas Codes Annotated*, requires testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin, and congenital adrenal hyperplasia on all newborns. This testing is the responsibility of any provider attending the birth of a baby (for example, physicians, CNMs). All infants must be tested a second time at one to two weeks of age. If there is any doubt that a child younger than 12 months of age was properly tested, the provider should submit the blood sample on the appropriate TDH Form NBS-3 to the TDH Newborn Screening Laboratory.

The provider should note the following:

- Results are mailed to the provider's address indicated on Form NBS-3.
- Laboratory recommendations for necessary follow-up procedures are included with the report.
- The TDH laboratory calls the provider in cases of significant abnormality.

Urinalysis. Urinalysis (i.e., dipstick) is performed at the discretion of the provider. Providers must purchase their own supplies. The cost for performing this service is included in the fee for medical checkup.

Refer to: "Laboratory Procedures" on page 89 for more information on laboratory collection techniques.

Follow-Up Care Guidelines Summary Table

Laboratory Results									Interpretation	Refer for Follow-up Care	Genetics Counseling
RPR Card			Hgb	Hgb Type		E.P.		Lead			
NR	R	Titer	g/dL	A: A	Other	<35 ug/dL	ug/dL	ug/dL			
X									Serological signs of syphilis not present.	No	
	X								Possible indication of syphilis. Further testing necessary.	Yes	
	X	1:1 etc.							Indication of degree of reactivity of laboratory result. 1:1, 1:2, 1:4, etc. Confirmed by TP-PA or FTA.	Yes	
								<10	Normal	No	
								10 - 14	Retest periodically. Refer to "Guidelines for Follow Up of Elevated Blood Leads" on page 95.	Yes	
								15 - 19	Retest periodically. Refer to "Guidelines for Follow Up of Elevated Blood Leads" on page 95.	Yes	
							35 - 249	20 - 69	Treatment needed. Refer to "Guidelines for Follow Up of Elevated Blood Leads" on page 95.	Yes	
							≥250	≥70	Emergency care needed. Refer to "Guidelines for Follow Up of Elevated Blood Leads" on page 95.	Yes	
				X					Normal adult hemoglobin present.	No	
					A, F				Probably normal on patients younger than 12 months. Percentage of F given if over 12 months. Should be retested after first birthday.	No	
					A, S				Probably sickle trait condition (carrier of sickle cell). Check patient history.	No	X
					A, F, S				Usually occurs in infants. Probably will result in sickle trait when F declines to normal adult levels.	No	X
					A,C				Probably C-trait condition.	No	X
				Probably A,D or A,G					Either D-trait or G-trait condition, but could be other Hgb having similar properties on electrophoresis.	No	X
				A, Other					Probable unknown trait condition. (Contact TDH for availability of complete structural analysis through reference laboratory.)	No	X
				S,S					Indicative of sickle cell disease. Total hemoglobin usually low (7 - 8 g/dL)	Yes	X
				S,F					Probably sickle cell disease. Should be checked for HPFH. If F < 20%, possible S-beta thalassemia.	Yes	X
				S,C					Probably indicative of hemoglobin S-C disease.	Yes	X
				C,C					Probably homozygous C disease.	Yes	X
				S,A					Probable S-beta thalassemia.	Yes	X
			<11.0						Probably anemic. Evaluate according to severity.	Yes	

2.2.3 Medical Checkups for Adolescents

Confidentiality Issues. THSteps has developed a summary of Texas laws addressing the following legal issues for all THSteps providers:

- Consent for the medical and mental health care of a minor
- Information discovered during an adolescent visit may be kept confidential

This information is helpful in understanding the rights of minors, parents, other guardians, and the provider. Direct questions about adolescent health care to the Adolescent Health Coordinator at 512-458-7111, ext. 2021. The adolescent health care Web site www.tdh.state.tx.us/adolescent/default.htm also contains information about the program.

2.2.3.1 Medical History

Information on current health status, past medical history, immunization, mental health, nutrition history, and family history should be obtained or updated at the time of the preventive health screening visit. Preferably, the adolescent and the parent should be interviewed separately.

2.2.3.2 Physical

The physical examination must include assessment of the following systems:

- Skin
- HEENT
- Dental
- Heart
- Chest/lungs (includes breast exam for females past menarche)
- Abdomen (including hernia)
- Skeletal
- Neurological (includes evaluation of cerebral, cranial nerve and cerebellar functions, motor and sensory systems, and reflexes)
- Genitalia (includes observation for appropriate sexual development and testicular exam for adolescent males and breast exam for adolescent females)

2.2.3.3 Measurements

The physical examination must include the following measurements for adolescents age 11–20:

- Height
- Weight
- BMI

2.2.3.4 Nutritional Assessment

The nutritional assessment is to be accomplished in the basic examination using the following methods:

- Identify unusual eating habits (such as pica) or diets that are deficient or excessive in one or more food groups by asking questions about dietary practices
- Determine quality and quantity of individual diets (e.g., dietary intake, food acceptance, meal patterns, methods of food preparation and preservation, and utilization of food assistance programs like WIC)
- Conduct a complete physical examination, including an oral dental examination, paying special attention to general features, such as pallor, apathy, and irritability

- Obtain accurate measurements of height and weight, which are important indices of nutritional status
- Conduct a laboratory screening for anemia (hemoglobin, hematocrit, erythrocyte protoporphyrin [EP]), as indicated

Risk Factors/Screening for Eating Disorders and Obesity. The risk factors/screening for eating disorders and obesity assessment is to be accomplished in the basic examination using the following methods:

- Adolescent should be asked about body image and dieting patterns.
- Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found:
    - Weight loss greater than 10 percent of previous weight
    - Recurrent dieting when not overweight
    - Use of self-induced emesis, laxatives, starvation, or diuretics to lose weight
    - Distorted body image
    - BMI below the fifth percentile
- Adolescents should have an in-depth dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease if they have a BMI equal to or greater than the 95th percentile for age and gender.
- Adolescents with a BMI between the 85th and 94th percentile are at risk for becoming overweight. A dietary and health assessment to determine psychosocial morbidity and risk for future cardiovascular disease should be performed on these youth if the following are true:
    - Their BMI has increased by two or more units during the previous 12 months
    - There is a family history of premature heart disease, obesity, hypertension, or diabetes mellitus
    - They express concern about their weight
    - They have elevated serum cholesterol levels or blood pressure

If this assessment is negative, these adolescents should be provided general dietary and exercise counseling and should continue to be monitored annually.

2.2.3.5 Mental Health

The mental health assessment is part of every comprehensive THSteps checkup. The purpose of the assessment is to identify problems in any of the following six domains:

- Feelings
- Behavior
- Social interactions
- Thinking
- Physical problems
- Other problems that may include substance abuse

Assessment may reveal several minor problems or one or more significant problems that warrant referral or provision of evaluation and, if indicated, treatment.

Refer to: "Guidelines for Mental Health Screening" on page 15.

2.2.3.6 Sensory Screening

Vision Screening. Adolescents must have their vision checked as part of the THSteps medical checkup screen.

For children ages 11 and older:

- Evaluate with letter chart or Tumbling E chart at ages 12, 15, and 18
- Refer if unable to read majority of 20/30 line
- Administer cover test or Random Dot E

Hearing Screening. At age 11 and older:

- The child or adolescent must be assessed with a puretone audiometric hearing screen (1000, 2000, 4000 Hz) and continue at ages 12, 15, and 18.
- The child or adolescent should have a subjective hearing evaluation, at ages 11, 13, 14, 16, 17, and 19–20 that includes patient history and observation of for the ability to answer questions and follow directions. Adolescents who do not respond to a 25 B tone at any frequency should be referred for a diagnostic hearing evaluation.
- Adolescents who receive audiometric testing as part of a school screening program may have those results documented, if known, in place of testing.

Refer to: "Hearing Referrals" on page 19 for information on PACT.

2.2.3.7 Additional Adolescent Screening

Alcohol and Drug Use. Ask about the use of alcohol and other substances (marijuana, cocaine, paint/glue sniffing and others), and over-the-counter or prescription drugs (for nonmedical purposes), including anabolic steroids.

Adolescents who report any use of alcohol or other drugs or inappropriate use of medicines during the past year should be assessed further regarding family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation about use, use of other drugs, and the adequacy of physical, psychosocial, and school functioning.

Adolescents whose substance use endangers their health should receive counseling and mental health treatment, as appropriate.

Adolescents who use anabolic steroids should be counseled to stop using steroids and about the danger of sharing needles.

The routine urine toxicology screening of adolescents is **not** recommended.

Adolescents who use alcohol or other drugs should also be asked about their sexual behavior and use of tobacco products.

Depression/Suicide Risk. Ask about behavior or emotions that indicate recurrent or severe depression or suicide risk.

Perform screening for depression or suicidal risk on adolescents who exhibit cumulative risk as determined by declining school grades, chronic melancholy, family dysfunction, homelessness, anxiety regarding homosexual orientation, physical or sexual abuse, alcohol or other drug use, previous suicide attempt, and suicidal inclination or plans.

If suicidal risk is suspected, adolescents should be evaluated immediately and referred to a psychiatrist or other mental health professional, or they should be hospitalized for immediate evaluation.

Nonsuicidal adolescents with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment.

Hyperlipidemia Screening. Hyperlipidemia (nonfasting blood cholesterol and fasting lipoprotein analysis) screening and follow-up services are to be provided in accordance with the following protocol developed by the Expert Panel on Blood Cholesterol Levels in Children/Adolescents:

- Adolescents who are older than age 19 years and who have a parent with a serum cholesterol level greater than 240 mg/dL should be screened for total blood cholesterol level (nonfasting) at least once.
- Adolescents who have a parent or grandparent with angina pectoris, coronary artery disease, documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death at 55 years or younger should be screened with a fasting lipoprotein analysis. A high proportion of these children will have some lipoprotein abnormality.
- Treatment options are based on the average of two assessments of low-density lipoprotein cholesterol (LDL). Values below 110 mg/dL are acceptable; between 110 and 120 mg/dL are considered borderline and lipoprotein status should be re-evaluated in one year. Adolescents with values of 130 mg/dL or greater should be referred for further medical evaluation and treatment.

Hypertension (Blood Pressure). Screening and follow-up services are to be performed following the protocol developed by the National Heart, Lung, and Blood Institute Second Task Force on Blood Pressure Control in Children.

Adolescents with either systolic or diastolic pressures at or above the 90th percentile for gender and age should have blood pressure measurements repeated at 3 different times within one month, under similar physical conditions, to confirm baseline values.

Adolescents with baseline blood pressure values greater than the 95th percentile for gender and age should have a complete biomedical evaluation to establish treatment options. Adolescents with blood pressure values between the 90th and 95th percentiles should be assessed for obesity and have their blood pressure monitored every 6 months.

Learning Problems. Ask about learning or school problems and noise exposure (music, motorcycles, cars, etc.).

Assess adolescents for a history of truancy, repeated absences, or poor or declining performance that could interfere with school success. Condition to assess include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, and alcoholic or other drug abuse.

This assessment and the subsequent management plan should be coordinated with school personnel and the adolescent's parents or caregivers.

Tobacco Use. Ask about use of cigarettes and smokeless tobacco. Adolescents who use tobacco products should be assessed further to determine their patterns of use. A cessation plan should be provided for adolescents who use tobacco products. A dental referral should be made for all adolescents with a history of tobacco use.

Physical, Sexual, or Emotional Abuse. Ask about history of emotional, physical, and sexual abuse.

If abuse is suspected, adolescents should be assessed to determine the circumstances surrounding the abuse and the presence of physical, emotional, and psychosocial consequences, including involvement in health risk behaviors.

Health providers should be aware of local laws about the reporting of abuse to appropriate state officials in addition to ethical and legal issues regarding how to protect the confidentiality of the adolescent patient.

Adolescents who report emotional or psychosocial sequelae should be referred to a psychiatrist or other mental health professional for evaluation and treatment.

Reporting Suspected Sexual Abuse. Reporting Abuse or Neglect, Rider 18 of Article II of the General Appropriations Act, House Bill 1, 76th Legislative Regular Session, 1999, requires TDH to ensure all Medicaid providers comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of child abuse and neglect reports, including suspected sexual abuse and TDH policy provisions.

Refer to: "Child Abuse Reporting Guidelines (2 Pages)" on page D-7 of the *Texas Medicaid Provider Procedures Manual* for more information.

Sexual Behavior/Sexually Transmitted Diseases (STDs). Ask about involvement in sexual behaviors during a general screening.

- Adolescents who are sexually active should be asked about their use and motivation to use condoms or barrier methods and contraceptive methods, their sexual orientation, the number of sexual partners they have had, if they have exchanged sex for money or drugs, and their history of prior pregnancy or STDs.
- Adolescents at risk for pregnancy, STDs (including human immunodeficiency virus [HIV]), or sexual exploitation should be counseled on how to reduce this risk.
- Adolescents who are sexually active should also be asked about their use of tobacco products, alcohol, and other drugs.

STD Screening Procedures for Sexually Active Adolescents. Sexually transmitted disease risk status includes the following:

- Having used intravenous drugs
- Having had STD infections
- Having lived in an area with a high prevalence of STDs or HIV infection
- Having had vaginal, anal, or oral sex
- Having exchanged sex for drugs or money
- Having had a sexual partner who is at risk for HIV infection (i.e., intravenous drug use)

Note: Testing should be performed only after informed consent is obtained from the adolescent.

HIV prevention counseling will be made available, which should include health guidance regarding responsible sexual behaviors, including abstinence. HIV prevention counseling should include the following:

- Counseling that abstinence from vaginal, oral, and anal intercourse is the most effective way to prevent pregnancy, STDs, and HIV infection
- Counseling on how HIV infection is transmitted, the dangers of the disease, and the fact that using latex condoms reduces the risk of transmission of HIV and some STDs
- Reinforcement of responsible sexual behavior for adolescents who are not sexually active currently and for those who use birth control and condoms appropriately
- Counseling on the need to protect themselves and their partners from pregnancy, STDs, HIV infection, and sexual exploitation

2.2.3.8 Tuberculosis Screening

THSteps requires a form of tuberculosis (TB) screening at every visit as noted on the adolescent preventive screen periodicity schedule. A questionnaire has been developed to determine if the adolescent is at high risk for TB and needs Mantoux TB skin testing. This questionnaire and guideline material was developed by the TDH TB Elimination Division and follows current CDC guidelines.

Note: Tracking of the completed TB Risk Questionnaire is no longer necessary. While the provider may choose to retain the questionnaire, the provider must document the screening, any risk factors identified, and any appropriate follow-up.

Providers should contact their local or regional health department to determine if their service area is a high-prevalence area for TB. A listing of counties with a high prevalence for TB also may be found at www.tdh.state.tx.us/tb/hiprev.htm.

In areas of low TB prevalence, the provider will administer the TB Risk Questionnaire annually. TB skin testing should be performed if the questionnaire indicates a risk factor or if the provider determines that a TB skin test is appropriate.

In areas of high TB prevalence, the provider will administer the TB skin test once between ages 11 and 16. If the client refuses the skin test or the child is uncooperative, administer the questionnaire. Administer the questionnaire annually beginning at age 2 and thereafter. In those age ranges where a skin test is recommended, the provider should administer the skin test at one of these ages and the questionnaire at the other annual checkups. The TB skin test also should be administered at these ages if a risk factor is indicated or the provider determines a skin test is appropriate.

Tuberculin tests are to be performed in the provider's office or clinic. The materials (PPD-Mantoux antigen and syringe) are distributed free of charge by the TDH local or regional health departments upon request. The cost of administering the test is included in the THSteps medical checkup fee. TINE testing materials are not supplied by TDH and should not be used.

If a follow-up screening visit is required to verify a presumptive positive reaction, the provider may bill the follow-up medical screening visit fee. Diagnosis and treatment are provided as a Medical office visit.

TB skin tests should be performed on adolescents who have been in contact with a case of active TB, have lived in a homeless shelter, have been incarcerated or live with someone who has been incarcerated, have lived or visit regularly in an area endemic for TB, currently work in a health care setting, are a recent immigrant from a country with a high prevalence of TB, or have associated with someone with HIV infection.

The questionnaire is to be used at each adolescent screening THSteps visit.

If any question on the questionnaire is answered with a "yes" or "I don't know," a TB skin test (Mantoux) is to be performed at the visit, unless medically contraindicated (e.g., has history of a previous positive PPD). If all questions are answered with a "no," the child or adolescent does not need to have skin testing, unless the provider believes it is needed for other medical reasons.

Any newly identified positive reactions should be evaluated by a screening provider or referred for evaluation. Report any suspected cases or diagnosed cases of TB to the local health department.

Refer to: "Guidelines: Tuberculosis Skin Testing (2 Pages)" on page G-157 for guidance on the evaluation of a positive skin test.
"TB Questionnaire" on page G-160.
"Cuestionario Para la Detección de Tuberculosis" on page G-161.

Obtaining Questionnaires. You may photocopy the questionnaires from this manual or order a maximum of 10 copies from the TDH THSteps Division at 512-458-7745.

2.2.3.9 Dental Assessment

Adolescent THSteps patients benefit from the evaluation of eruption pattern, decay prevalence, oral hygiene practice, and from other comprehensive observations. Hormonal changes of the body at adolescence often precipitate amplified oral soft tissue changes. Soft tissue irritants in these adolescent patients can provoke significant tissue responses.

Patients with diabetes and patients under long-term medication therapy should be educated in potential gingival manifestations if daily oral health hygiene practice is not observed. Physician reinforcement of the need for thorough daily oral hygiene practices, as well as utilization of the THSteps eligibility for dental services, can greatly benefit the client.

The prevalence of the use of smokeless tobacco products by teens and preteens creates a high need to evaluate the patient for deterioration of oral hard and soft tissue. Examination of the mucobuccal fold (cheek area) and sublingual area for leukoplakia is indicated. White to various stages of edematous red patches can be readily identified and pointed out to the patient, and assistance offered in cessation, with minimal office time involvement.

Oral cancer prevalence is expanding in many population groups. Early intervention and reinforcement of the need for cessation by the medical community have been shown to have a significant positive impact on the "early user."

THSteps Dental Services. Access to THSteps dental services is mandated by Medicaid and provide reimbursement for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than age 21. THSteps dental service standards were designed to meet federal regulations and to incorporate the recommendations of representatives of dental professional groups in the state.

Refer to: "THSteps-CCP Overview" on page 40-20 of the *Texas Medicaid Provider Procedures Manual* for more information.

The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandated the expansion of the federal EPSDT program to include any service that is medically necessary and for which FFP is available regardless of the limitations of the Texas Medicaid Program. This expansion is referred to as the Comprehensive Care Program (CCP).

Follow-Up Dental Care and Referrals

If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnoses or treatment, the provider performing the dental checkup should assist the client in planning follow-up care or in making a referral to the qualified provider. The *Texas Medicaid Provider Procedures Manual* provides information regarding covered benefits, getting assistance to identify qualified providers, and how to code and bill for services covered by the THSteps program, THSteps-CCP, or traditional Medicaid program.

For service delivery areas where the Medicaid-eligible client is enrolled in an HMO, the dental care will be provided by a Medicaid-enrolled dentist (fee-for-service); however, nondental adjunct providers, such as the facility and anesthesiology care, must be HMO network providers or previously approved by the HMO.

2.2.3.10 Health Guidance

Adolescent Development. Give adolescents the following health guidance:

- Promote a better understanding of their physical growth, and their psychosocial and psychosexual development
- Promote the importance of becoming involved in decisions about their health care

Safety Practices. Give adolescents health guidance on the following injury prevention techniques:

- Avoid the use of alcohol or other substances while using motor or recreational vehicles, or where impaired judgment may lead to injury
- Use safety devices, including seat belts, motorcycle and bicycle helmets, and appropriate athletic protective devices
- Resolve interpersonal conflicts without violence
- Avoid the use of weapons and promote weapon safety
- Obtain appropriate physical conditioning before exercise

Diet and Fitness. Give adolescents health guidance on the following diet and fitness guidelines:

- Benefits of a healthy diet
- Ways to achieve a healthy diet
- Safe weight management

- Benefits of exercise
- Safe exercise on a regular basis
- Benefits of adequate rest

Healthy Lifestyles. Give adolescents health guidance on the following healthy lifestyle guidelines:

- Avoiding tobacco, alcohol, high noise exposure, other abusable substances, and anabolic steroids
- Abstaining from vaginal, oral, and anal intercourse as the most effective way to prevent pregnancy and sexually transmitted diseases (STDs), including HIV infection
- Transmitting of the HIV infection, the dangers of the disease, and the fact that latex condoms are effective in reducing the risk of some STDs, including HIV infection
- Reinforcing of responsible sexual behavior for adolescents who are not currently sexually active and for those who are using birth control and condoms appropriately
- Protecting themselves and their partners from pregnancy, STDs, including HIV infection, and sexual exploitation

2.2.3.11 Laboratory Tests Related to Medical Checkups for Adolescents

The TDH Bureau of Laboratories must perform lab-screening tests for THSteps clients for cholesterol, HIV, gonorrhea/chlamydia, and syphilis. The **TDH-Women's Health Laboratories, Cytopathology Department** performs Pap smear screening for THSteps clients.

Laboratory specimen collection testing materials and necessary forms and supplies are free to all enrolled THSteps medical providers. The information presented describes laboratory test procedures, interpretation of laboratory test results, guidelines, and criteria for follow-up, as well as helpful information on specimen collection and handling.

Communicable Disease Reporting. Diagnoses of sexually transmitted diseases (STDs), including HIV, are reportable conditions under Title 25 Texas Administrative Code (TAC), Chapter 97. Providers must report confirmed diagnoses of STDs as required by 25 TAC 97.132.

Cervical Cancer Screening. This test should be conducted on all sexually active females and females age 18 years and older. The Pap smear test is a microscopic examination of cells exfoliated or scraped from a mucosal surface. This test is most widely used in detecting malignant, premalignant, and infectious disease of the uterine cervix.

Laboratory Procedure

Specimens for the Pap smear must be sent to the TDH-Women's Health Laboratories in San Antonio. Pap smears arrive by mail or courier service and are processed in the Cytopathology Laboratory. The slides are stained with the Pap stain technique and coverslipped. Staff cytotechnologists examine all Pap smears for cellular disease and render a diagnosis on those determined to be negative or abnormal.

A quality control cytotechnologist rescreens at least 10 percent of the cases considered negative by the staff cytotechnologists. All abnormal cases are referred to a pathologist for final interpretation and follow-up recommendation. A computer-generated result report is mailed or faxed to the submitting THSteps medical checkup provider. A statistical report is mailed monthly to providers documenting their totals by diagnosis and adequacy.

Patient Preparation

A carefully obtained smear provides the cytologist with an optimal specimen for interpretation. A Pap smear should be obtained under the following ideal conditions when possible:

- The patient is not menstruating.
- Nothing has been placed in the patient's vagina during the past 24 hours.
- The Pap smear is the FIRST specimen collected if multiple specimens are to be obtained.

Two types of Pap smear tests are available; **conventional** and **liquid-based**.

Conventional Pap smear

The following materials are needed to perform a conventional Pap smear:

- Glass slide with frosted end (label patient's name, birth date, and source of specimen on frosted end)
- Cardboard container
- Spatula AYRE's type with extended tip cytobrush (do **not** use cytobrush on pregnant patients)
- Spray fixative
- Speculum
- Gloves
- Pencil #2
- M-47 requisition slip

Precautions

Take the following precautions during the procedure:

1) Smears should not be thick or bloody.
2) Smears should be "fixed" immediately.
3) If more than one source is sampled, identify slides with source of specimen.
4) The margins and not the crater of a grossly ulcerated area should be scraped.

Procedure

To perform a conventional Pap smear, follow these steps:

1) Obtain portio specimen. Place the end of the spatula on the portio and rotate through 360 degrees several times, scraping the surface to include the entire transformation zone. Spread the material evenly over the entire slide.
2) Obtain endocervical specimen. The cytobrush is the preferred instrument, however, a saline moistened cotton swab may be used instead, particularly in a pregnant patient. Insert one cytobrush or cotton swab into the endocervical canal and rotate several times. Then roll the sample evenly over the entire slide applying it over the portion sample.

Note: Steps 1 and 2 should be performed carefully, but quickly. Once both specimens, portio and endocervical, have been applied to the slide, they should be spray fixed within a few seconds.

3) Place slide in a cardboard container. Allow slide to dry completely before closing the container. Otherwise, the slide may stick to the surface of the cardboard and increase the possibility of breakage during transport. The cardboard fiber can also absorb moisture from the smear and result in air-dried cells.

Liquid-based Pap Smear

Materials

The following materials are needed to perform a liquid-based Pap smear:

- Cervex brush
- Liquid-based preservative vial
- M-47 test request form
- Specimen transport bag

Procedure

To perform a liquid-based Pap smear, follow these steps:

1) Write the patient's name and date of birth on the liquid-based preservative fluid vial.
2) Explain the pelvic examination and liquid-based Pap smear process to the patient.
3) Insert the central bristles of the cervex brush into the endocervical canal.
4) Maintaining gentle pressure, rotate the cervex brush five times in a clockwise direction.
5) Insert the cervex brush into the cytorich preservative fluid vial and separate the broom part of the device from the handle by pulling it apart, leaving the broom in the collection vial. Discard the stem of the collection device.
6) Cap the vial tightly and shake. Place the vial in a zip-lock biohazard transport bag. Make sure the vial is closed securely to prevent leakage.
7) Mail to TDH-Women's Health Laboratories in San Antonio.

Note: The cervex brush should not be used on patients after the first 10 weeks of pregnancy.

Request Form

Follow these steps to submit a request form:

1) Submit a test request form (Form M-47).
2) Make sure the slide and request form (or liquid-based Pap vial) are labeled with the patient's last name. Wrap completed M-47 form around cardboard mailer for conventional Pap smears and fasten with rubber band. For liquid-based Pap smears, place vial in zip-lock biohazard transport bag and place M-47 in the corresponding pocket.
3) The completed M-47 form must include the following information:
   - Name as it appears on Form 3087
   - Address
   - Date of birth
   - Social Security number
   - Date of service
   - Examiner
   - ICD-9-CM diagnostic code for the visit or a descriptive narrative
   - Test(s) ordered
   - Specimen site (cervix, endocervix, vaginal)
   - Submitting clinic code or name and address of clinic
4) The completed test request form must include the Medicaid number or "Medicaid Pending" must be written on the form for billing purposes.

Mailing Specimens and Ordering Supplies

THSteps providers can call for information, mail their specimens, or order supplies for obtaining Pap smears for THSteps adolescent screening from the following laboratory:

Women's Health Laboratories
2303 SE Military Drive
Suite 1
San Antonio TX 78223
Customer Service: 888-440-5002
Fax: 210-531-4506
Kathy Allen: 210-534-8857, extension 2357
e-mail: Kathleen.Allen@tdh.state.tx.us

Follow these steps to order supplies:

- Use order Form AG-30, 1643 or letterhead stationery.
- Fax supply order form or include in specimen packaging.
- Request supplies by telephone or e-mail.
- Include your THSteps TPI.

The following supplies are available for order:

Conventional Pap Smears	Surepath Liquid-Based Pap Smears
Frosted slides	Cervex brush
Cytocervial brush	Cytorich preservative vial
Cyto fixative	M-47 form
Cardboard slide mailers	Zip-lock biohazard transport bag
M-47 forms	Cardboard boxes
Cervical scrapers	Labels
Cardboard boxes	AG-30 supply order form
Labels	
AG-30 supply order form	

Note: Providers who are already on the automated system through the TDH Pharmacy Division are requested to continue using this system. Larger numbers of supplies are sent through the TDH Pharmacy.
Providers with consistent monthly workload volumes can request to be set up with a "Standard Monthly Order" that will be shipped at the same time each month.

Interpretation of Test Results

The laboratory uses the Bethesda System of reporting cytology results. The following are cytology results terms and their definitions:

- Specimen Upon Receipt – Refers to the condition of the glass slide and request form upon receipt into the laboratory before it is tested. Whether it is **adequate** to test or **other** is determined upon receipt. **Other** signifies that the slide or request form is not satisfactory and an explanatory comment follows.
- Statement of Adequacy – Refers to the adequacy of the cellular sample at the time of microscopic review. One or two possible statements is given to describe the adequacy of the specimen:
  - **Satisfactory** – Indicates the specimen is satisfactory for interpretation.
  - **Unsatisfactory** – Indicates the specimen is unsatisfactory for interpretation and a reason is given.
- Cytology Diagnosis – Refers to the primary interpretation of the sample:
  - **Unsatisfactory** – Indicates the specimen is unsatisfactory for interpretation and a reason is given.
  - **Negative for Intraepithelial Lesion or Malignancy** – Used when no epithelial abnormalities are found.
  - **Atypical Squamous Cells of Undetermined Significance** – Consists of atypical squamous cells in which it is difficult to distinguish between a reactive and premalignant process.
  - **Atypical Squamous Cells Cannot Exclude High-Grade Lesion** – Consists of atypical squamous cells that may result from a reactive process or from high-grade dysplasia.

- **Atypical Glandular Cells** – Consists of atypical glandular cells of endocervical origin, endometrial origin, or origin not specified.
- **Low Grade Squamous Intraepithelial Lesion** – Consists of epithelial abnormalities with descriptive diagnosis of Human Papilloma Virus (HPV) or mild dysplasia.
- **High Grade Squamous Intraepithelial Lesion** – Consists of epithelial abnormalities with descriptive diagnosis of moderate dysplasia, severe dysplasia, or carcinoma in situ.
- **Positive For Malignancy** – Used when malignancy is diagnosed, squamous cell carcinoma, adenocarcinoma, or other neoplasm.
- **Endometrials Present** – Used when endometrial cells are present in a smear on a woman over 40 years of age.

- Recommendation – Based on the cytologic finding, a recommendation for patient follow-up may be made. Clinical indications may suggest that other follow-up is more appropriate.

Hemoglobin or Hematocrit. Specimens for hemoglobin levels must be sent to the TDH laboratory.

Hemoglobin or hematocrit levels are required as a screening procedure to indicate anemia resulting from poor diet or diseases. The required minimum frequency for hemoglobin or hematocrit testing is at ages 12 and 16.

The provider should note that the TDH laboratory uses the cyanmethemoglobin method to measure hemoglobin only and calls the provider when analysis indicates a hemoglobin result of 7 g/dL or less.

Hemoglobin Type. Specimens for hemoglobin type must be submitted to the TDH laboratory. If the hemoglobin type has been performed, including as a part of newborn screening and results are documented on the chart, it does not need to be repeated. It also may be performed at the provider's discretion as appropriate for age and population groups. For instance, certain children need this procedure to screen for sickle-cell disease or trait.

The provider should note the following when checking for hemoglobinopathies:

- TDH uses isoelectric electrophoresis for initial screening. Confirmatory analysis (for HbS, HbC, HbE, HbO, etc.) is made using isoelectric focusing or citrate agar electrophoresis as necessary.
- Laboratory reports list the hemoglobin types detected. In cases where definitive results are not possible, appropriate explanations are provided. Notes are also entered if results are clinically significant.
- Quantitative figures are reported only in the following instances:
  - HbF present in a patient older than age 1
  - Elevated A2 detected (possible thalassemia)

Hyperlipidemia Testing. Three main classes of lipoproteins can be measured in the blood:

- Very low density lipoproteins (VLDL)
- Low density lipoproteins (LDL)
- High density lipoproteins (HDL)

LDL and HDL mainly transport cholesterol, and VLDL is the major carrier of triglycerides. Genetic abnormalities in the metabolic pathways of one or more lipoproteins may produce increases in the levels of cholesterol, triglycerides, or both.

Laboratory Procedure

The lipoproteins are analyzed on an automated chemistry analyzer using a reagent system specific for the quantitative enzymatic measurement of total serum cholesterol.

The lipid profile performed on at-risk adolescents includes the measurement of total blood cholesterol, triglycerides, and HDL, as well as a calculated value for the LDL. These tests are also performed on an automated chemistry analyzer using reagent systems specific for these analyses.

Interpretation of Test Results Cholesterol Screen

Lipid Profile/At-Risk Patients

After a lipoprotein analysis has been obtained, it should be repeated within 18 weeks to obtain averaged test results for cholesterol and LDL on the consecutive specimens. The average LDL result is considered the most significant indicator for determining the risk status and therapeutic needs of these patients.

Cholesterol Screen		
Cholesterol mg/dL	**Interpretation**	**Refer for Follow-up Care**
<170	Within desirable limits. Rescreen in five years.	No
170-199	Repeat cholesterol in 1–8 weeks Average the two results. a. If average <170 mg/dL, rescreen in five years. b. If average ≥ 170 mg/dL, individual may be at risk for developing hyperlipidemia and adult coronary heart disease.	 a. No b. Yes
≥200	Indicative of increased risk for developing hyperlipidemia and coronary heart disease.	Yes

Desired Results	
Cholesterol:	<170 mg/dL
Triglycerides:	30-190 mg/dL
HDL:	>35 mg/dL
LDL:	<110 mg/dL

Lipid Profile/At-Risk Patients			
Average Total Cholesterol (mg/dL)	**Average LDL (mg/dL)**	**Interpretation**	**Referral for Follow-up Care**
<170	<110	Acceptable: Provide education on recommended eating patterns and CHD risk factors, repeat lipoprotein analysis in 5 years.	No
170-199	110-129	Borderline: Patient needs appropriate education, risk factor intervention, and diet therapy before re-evaluation.	Yes
≥200	≥130	High-Risk: Patient needs further evaluation for secondary causes and familial disorders, diet therapy, and in extreme cases, drug therapy.	Yes

Specimen Collection and Handling

Submit a vial of blood with the specified volume marked on the vacutainer to the TDH Bureau of Laboratories. A separate tube must be submitted for this analysis, regardless of any additional THSteps laboratory screening procedures being performed at the same time.

Collection technique is a standard venipuncture method. After collecting the specimen in a red-topped blood collection tube, label the tube with the patient's first and last name as recorded on the laboratory request form. It is not necessary or recommended to centrifuge and separate the serum portion. If you are unable to mail within 24 hours, refrigerate the specimen, but do not hold for more than 3 days.

STD Testing.

Gonorrhea/Chlamydia Infection Testing

Gonorrhea and chlamydia infections are the most common reportable sexually transmitted diseases in the United States today. Neisseria gonorrhoeae is the bacterium that causes gonorrhea; chlamydia trachomatis is the microorganism responsible for chlamydia infection. Infection with either of these organisms usually results in an anterior urethritis accompanied by a purulent discharge in males. In females, these diseases usually infect the cervix; however, the vagina and uterus may also be involved. Asymptomatic, coexisting infections are frequently diagnosed, and for this reason, sexually active adolescents are tested for both these diseases simultaneously. Untreated infections may result in severe complications, including sterility and pelvic inflammatory disease.

Laboratory Procedure

Specimens for gonorrhea and chlamydia screening must be sent to the TDH laboratory that uses the Gen-Probe Pace 2C system to screen for these infections.

This methodology uses DNA probe technology and permits testing for gonorrhea and chlamydia infection from a single swab. The laboratory procedure is based on the alignment of the target microorganism's ribosomal RNA with complementary single-stranded DNA probes. If either microorganism is present in the sample, a stable DNA:RNA hybrid will form as the organism's RNA aligns with one of the chemiluminescent labeled DNA probes. The labeled DNA:RNA hybrid is magnetically separated from the nonhybridized DNA probe and then measured for chemiluminescence. Test results are calculated from the difference between the response of the specimen and the mean response of negative reference specimens. A positive or indeterminate specimen is retested with the single-organism specific Gen-Probe Pace 2 system to identify the specific organism that is causing the infection.

This procedure avoids the need for culturing the specimen to recover the microorganisms, thus permitting faster laboratory turnaround and lower unsatisfactory specimen rates. The Gen-Probe Pace 2 system has been used successfully at the TDH laboratory since 1991 because of the procedure's excellent sensitivity and specificity.

Important: THSteps providers are advised that specimens associated with medicolegal problems are not to be tested with the Gen-Probe Pace 2 methodology.

Interpretation of Test Results

A positive result for gonorrhea or chlamydia infection indicates the presence of infection and a need for patient referral and treatment. It must be understood, however, that this screening procedure may yield a low percentage rate of false-positive results. Therefore, it is advisable to repeat the Gen-Probe screening test or perform a culture test on specimens from low-risk patients who have no typical symptoms or history of exposure, but demonstrate a positive screening test result. Negative results indicate absence of the infection. Although the Gen-Probe procedure has been evaluated as a very reliable procedure, the validity of the results can only be as good as the quality of the specimen. A negative result does not exclude the possibility of infection because test results may be affected by improper specimen collection. Any individual with recent exposure to gonorrhea or chlamydia should be treated prophylactically. Unsatisfactory test results may occur in the following instances:

- Transport fluid leaks from the tube during mailing.
- The incorrect swab is used. The quantity of fluid in the male collection kit is different from that designed for females. It is critical to use the correct collection kit.
- Swabs collected from oral or rectal sites are unsuitable for this procedure.

- Specimen contains a gross quantity of blood. Generally, bloody specimens can be tested, but large amounts of blood may interfere with assay performance and are noted on the lab report.
- Collector is submitted without a swab or with multiple swabs.
- Specimen arrives more than seven days after collection.

Specimen Collection and Handling

Collect swab specimens as follows:

Cervical Swab Specimens

1) Using a female collector, remove excess mucus from the cervical os and surrounding mucosa using one of the swabs in the kit or a jumbo (Proctor) swab. Discard the swab.
2) Insert the second swab from the collection kit 1 to 1 ½ cm (½ to ¾ inch) into the endocervical canal.
3) With mild pressure, rotate the swab through several 360 degree rotations in both directions in the endocervical canal to ensure adequate sampling. Leave the swab in for 10 to 30 seconds.
4) Withdraw the swab carefully, avoiding any contact with the vaginal mucosa.
5) Insert the swab into the Gen-Probe Transport Tube; break off or cut swab shaft to fit the tube and cap the tube separately.

Urethral Swab Specimens

1) Using a male collector, collect a specimen only from patients who have not urinated for at least one hour.
2) Collect the urethral specimen by inserting the swab from the urethral collection kit 2 to 4 cm (¾ to 1 ½ inches) into the urethra using a rotating motion to ease insertion.
3) Rotate the swab gently, using sufficient pressure to ensure that the swab contacts all urethral surfaces; allow the swab to remain inserted for 2 to 5 seconds.
4) Withdraw the swab.
5) Insert the swab into the Gen-Probe Transport Tube; break off or cut the swab shaft to fit the tube and cap the tube securely.

Conjuctival Specimens

Swab any area appearing inflamed or infected. Specimens will be tested for chlamydia only. Label the specimen transport tube with the patient's first and last name. Before mailing, be sure the cap is tight. Leakage of the transport fluid will result in an unsatisfactory specimen. Provide all information requested on the test request form.

Mail the collection tubes daily to the TDH laboratory. If you are unable to mail within 24 hours, the specimen should be refrigerated. Do not hold for more than 3 days. The collection tubes should not be frozen, nor reach temperatures above 85 degrees Fahrenheit. Swab specimens must reach the testing laboratory within 7 days after collection.

HIV Testing. It is critical to maintain patient confidentiality when caring for patients, as well as their specimens. Do not leave specimens identified for HIV testing in open view of unauthorized medical personnel. Discussions with patients regarding their risk-factors should be confidential. **Testing should be performed only after informed consent is obtained from the adolescent. Do not mail** patient consent to the laboratory; retain with patient records.

HIV testing may be performed on adolescents without requirement of parental consent. Adolescents at risk for HIV infection should be offered confidential HIV screening.

Pregnant females are required to be tested for HIV, syphilis, and hepatitis B at their first prenatal visit and again at delivery. Health and Safety Code §81.090 requires the health care provider to distribute information about syphilis, HIV, and hepatitis B to the patient. The health care provider must also verbally inform the client of the following:

- That an HIV test will be performed unless she objects to the HIV test
- That the result of the HIV test is confidential, not anonymous
- The difference between anonymous and confidential HIV testing

If the client refuses the HIV test, the provider may not perform the test and must explain the option of anonymous testing and refer the client to a testing facility that offers anonymous testing. A notation must be made in her medical record that the distribution of materials was made and verbal notification of the HIV test and the right to refuse was given.

If a test indicates the pregnant client is infected with HIV, the provider must give the client information about the treatment of HIV/AIDS and refer her to an entity that provides HIV treatment. Health and Safety Code §81.090 requires, if resources permit, the physician or other person to make information available in another language and in a manner and terms understandable to a person who may be illiterate, as needed.

Laboratory Procedure

Specimens for HIV screening must be sent to the TDH laboratory. The presence of HIV-1 antibodies in patient serum is a long-term marker of infection. Specimens are tested on an enzyme immunoassay (EIA) that identifies patient antibodies that are specific for the HIV-1 virus. Specimens that are initially reactive on the EIA screen are retested in duplicate on the EIA. If either of the duplicate retests are reactive, the EIA is considered repeatedly reactive and a confirmatory test, the Western blot, is performed. The Western blot involves the separation of the virus proteins by size on a special strip of filter paper. This strip is soaked in a dilution of patient serum. If antibodies specific for the different proteins are present, they will bind to that portion of the strip. The antibodies are then detected with enzyme-labeled antibodies that cause a darkening on the strip where patient antibodies have bound. Western blot bands are named by a letter indicating the type of molecule, p=protein, gp=glycoprotein, and a number that indicates their relative size in kilodaltons (for example, p17=a protein 17 kilodaltons in size).

Interpretation of Laboratory Results

Laboratory report forms state whether the HIV-1 EIA result is nonreactive, reactive, or unsatisfactory. Interpretation of a nonreactive EIA result must take into consideration the patient's recent risk factors; a period of time from exposure (as soon as six weeks, but up to six months) is required before antibodies will be produced to the virus in detectable quantities. This process is called seroconversion or the window period. A reactive EIA result also has an attached report of the Western blot test result that may be nonreactive, reactive, or indeterminate. The minimum criteria for a reactive Western blot is antibodies present for any two of the following viral protein bands: p24, gp41, and gp120/160. Indeterminate Western blot patterns do not meet the minimum criteria, and although this is not common, it may be an indication that seroconversion is taking place. Because of this, the patient should be retested after eight weeks.

Specimen Collection and Handling

Submit a red top collection tube full of blood to the TDH laboratory separately, regardless of any other THSteps laboratory screening procedures being performed simultaneously.

Collection technique is the standard venipuncture method. After collecting the specimen, label the tube with the patient's first and last name as recorded on the laboratory request form. It is not necessary or recommended to centrifuge and separate the serum portion. If unable to mail within 24 hours, refrigerate the specimen, but do not hold for more than 3 days.

Syphilis Testing. Syphilis testing should be performed on adolescents who are at high-risk for infection. These high-risk adolescents include sexually active individuals living in an area with a high prevalence of STD, endemic for syphilis, or individuals at risk (e.g., past family history or prior

history of other STDs or on adolescents who have had vaginal, anal, or oral sex, or have had a sexual partner who is at risk for infection). Rapid Plasma Reagin (RPR) is no longer a required test, but should be obtained based on risk assessment.

Laboratory Procedure

Specimens for syphilis screening must be sent to the TDH laboratory. A Rapid Plasma Reagin (RPR) Card Test is the screening procedure. Collect whole blood in a 6 mL clot tube (red top). The provider should note the following:

- The RPR Card Test is a macroscopic nontreponimal testing procedure similar in sensitivity and reliability to the venereal disease research laboratory (VDRL).
- False-positive reactions occur with variable frequency as a result of reagin produced in diseases other than syphilis or provoked by immunization antigens.
- The RPR Card Test cannot be performed if hemolysis of the sample has occurred or if sample volume is less than 0.5 ml. Specimens found reactive by RPR Card Test are confirmed for syphilis by Treponema Pallidum-Particle Agglutination (TP-PA) tests or Fluorescent Treponemal Antibody Absorbed (FTA) tests.

Case Management for Children and Pregnant Women (CPW)

Case management services are provided to assist eligible clients in gaining access to necessary medical, social, educational, and other services, encourage cost-effective health and health-related care, discourage over utilization or duplication of services, and make appropriate referrals to providers. Case managers provide the necessary coordination with providers of services when these services are needed by a client.

Refer to: "Case Management for Children and Pregnant Women (CPW)" on page 12-1of the *Texas Medicaid Provider Procedures Manual* for more information on case management services.

THSteps-CCP

If children younger than age 21 have abnormal results on the THSteps checkups, screenings, or laboratory tests, the Texas Medicaid Program also provides funds for appropriate follow-up care. Physicians who provide THSteps checkups may be able to diagnose and treat the finding in their office. For the Medicaid fee-for-service program, see the *Texas Medicaid Provider Procedures Manual* for information about coding and billing for these services. When abnormal findings require referral for diagnosis and treatment by specialty providers, the physician may be able to do that directly or need to get prior approval from TDH or its designee, TMHP. For services covered under the traditional Medicaid program, instructions are in the *Texas Medicaid Provider Procedures Manual*.

For those services covered under THSteps-CCP, the primary or specialty providers must contact TMHP for prior approval. For example, THSteps-CCP covers private duty nursing, customized durable medical equipment, therapies, inpatient psychiatric services, outpatient psychiatric services beyond traditional Medicaid benefits, nutrition counseling, and unlimited pharmaceuticals. These services require documentation of medical necessity and prior approval.

The Texas Medicaid Program continually reviews current policies and requests for coverage of new health and health-related services. When Medicaid policies are revised or adopted, information and implementation instructions are published in the bimonthly *Texas Medicaid Bulletin*.

For Medicaid-eligible children enrolled in a Medicaid Managed Care Organization (MCO), all the same benefits must be provided as described in the *Texas Medicaid Provider Procedures Manual*. Reimbursement and precertification requirements are negotiated through contracts and other

agreements between the State of Texas or one of its contracting MCOs and the providers. Providers are referred to the appropriate provider manuals of the Medicaid MCOs. Providers may contact HHSC, either through the program offices in Austin or the regional offices.

Refer to: "Communication Directory" on page 85 for contact information.

THSteps Dental

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Texas Health Steps (THSteps) is the Texas version of the Medicaid service known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The dental care benefits are available to Medicaid-eligible children up to age 21.

3.1 Provider Enrollment

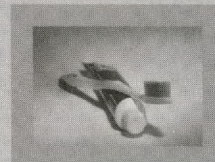
To become a provider of THSteps or intermediate care facility-mental retardation (ICF-MR) dental services, a dentist must:

- Currently be licensed by the Texas State Board of Dental Examiners (TSBDE)
- Practice within the scope of his or her professional licensure
- Complete an enrollment application with TMHP
- Submit a copy of his or her current licensure by the TSBDE and anesthesia permits

Contact TMHP Customer Service at 800-925-9126 to request application forms. Out-of-state dentists should refer to "Medical Service Provided Outside Texas" on page 3-4 of the *Texas Medicaid Provider Procedures Manual*.

Refer to: "Provider Enrollment and Responsibilities" on page 2-1 of the *Texas Medicaid Provider Procedures Manual* for more information about enrollment procedures.

A dentist must complete an enrollment application for each separate practice location and will receive a unique nine-character Texas Provider Identifier (TPI) if the application is approved.



The application form includes a written agreement with the Health and Human Services Commission (HHSC), the single state Medicaid agency.

Refer to: "Doctor of Dentistry Practicing as a Limited Physician" on page 18-5 of the *Texas Medicaid Provider Procedures Manual* for information on Doctor of Dentistry enrollment.

3.1.1 Provider Enrollment Requirements

Providers interested in enrolling in the Medicaid program must be licensed actively with the TSBDE. Dental licensure for owners of a dental practice is a requirement of Chapter 251, *Vernon's Texas Codes Annotated (V.T.C.A.),* General Provisions Relating to the Practice of Dentistry (the Dental Practice Act). All owners of a dental practice must maintain an active license status with the TSBDE to receive reimbursement from Medicaid. Any change in ownership or licensure must be reported in writing to TMHP Provider Enrollment.

Refer to: "Provider Enrollment and Responsibilities" on page 2-1 of the *Texas Medicaid Provider Procedures Manual*.
"Maintenance of Provider Information" on page 2-5 of the *Texas Medicaid Provider Procedures Manual*.

Dental providers may enroll in THSteps and ICF-MR dental programs or as a Doctor of Dentistry Practicing as a Limited Physician, or both. Note the enrollment requirements are different in respect to the enrollment category.

Dentists must specify a category of practice by choosing one of the specialties listed in "Categories of Practice" on page 18-5 of the *Texas Medicaid Provider Procedures Manual*. Changes of licensure status or category of practice must be reported immediately and will affect reimbursement by the Medicaid program.

The individual dentist must designate that he or she will provide primary services within a specific category of practice.

Regardless of the category of practice type (see "Categories of Practice" on page 49) designation under THSteps Dental, providers can bill only for THSteps/ICF-MR services.

Refer to: "THSteps Dental Services" on page 18-6 of the *Texas Medicaid Provider Procedures Manual* for more information on claims reimbursement.
"Categories of Practice" on page 18-5 of the *Texas Medicaid Provider Procedures Manual.*

3.1.1.1 THSteps Dental and ICF-MR

Providers may enroll as a group practice or as an individual dentist.

The individual dentist must designate that he or she will provide primary services within a specific category of practice (see "Categories of Practice" below).

Regardless of the category of practice type designation under THSteps Dental, providers can bill only for THSteps/ICF-MR services.

Refer to: "THSteps Dental Services" on page 18-6 of the *Texas Medicaid Provider Procedures Manual* for more information on claims reimbursement.

3.1.1.2 Doctor of Dentistry (DOD) Practicing as a Limited Physician

Providers may enroll as a dental group or as an individual dentist.

To enroll as a Doctor of Dentistry Practicing as a Limited Physician, a dentist must:

- Currently be licensed by the TSBDE or currently be licensed in the state where the service was performed at that time
- Have a **Medicare** provider identification number before applying for and receiving a **Medicaid** TPI
- Enroll as a Medicaid provider with a limited physician TPI

3.1.1.3 Categories of Practice

All dental providers must declare one of the following categories:

- General practice
- Pediatric dentist
- Periodontist
- Endodontist
- Oral and maxillofacial surgeon
- Orthodontist
- Other (prosthodontist, public health, and others)

3.2 THSteps and ICF-MR Provision of Services

All THSteps and ICF-MR dental services shall be performed by the enrolled provider, except for permissible work done by a licensed dental hygienist, dental assistant, or dental technician in a dental laboratory on the premises where the dentist practices or in a commercial laboratory registered with the TSBDE. The Texas Dental Practice Act (Occupations Code, Chapter 251) and the TSBDE rules and regulations (22 TAC, Part V) define the scope of work that dental auxiliary personnel may perform. Any deviations from these practice limitations shall be reported to the TSBDE and HHSC, and could result in sanctions or other actions imposed against the provider.

According to federal Medicaid guidelines, dental services that are not covered under the THSteps Dental Program for which dental necessity has been established and federal financial participation (FFP) is available, may be considered for THSteps-eligible clients through the Comprehensive Care Program (CCP).

3.3 How the Program Works

THSteps designated staff (TDH, TDHS, or contractor), through outreach and information, encourage eligible children to use THSteps dental checkups and prophylactic care when children first become eligible for Medicaid and each time children are periodically due for their next dental checkup.

Upon request, TDH (or its contractor) will assist eligible children with scheduling and transportation. Children within regular Medicaid have free choice of providers and are given names of enrolled providers. Call 877-847-8377 for a list of THSteps dental providers in a specific area.

When the child is eligible for a THSteps dental checkup, a message is present on the Medicaid Identification Form (3087) under the child's name. If the child or care giver believes the child is due for a dental checkup and a message is not present, the provider may contact TMHP through the TMHP Provider Web site or the Medicaid Automated Inquiry System (AIS) to verify that the child is due for a dental checkup.

Children may receive an initial THSteps dental checkup at the age of 12 months and a periodic dental checkup every 6 months thereafter through age 20. Children younger than age 12 months are not eligible for **routine** dental examinations; however, they may be referred when a medical checkup identifies the medical necessity for dental services. Children younger than age 12 months can be seen by the dentist at any time for emergency dental services for trauma, baby bottle tooth decay, or any other appropriate dental or therapeutic procedure.

Clients up to age 21 may self-refer for dental services.

3.4 Client Rights

Dental providers enrolled in the Texas Medicaid Program enter into a written contract with TDH to uphold the following rights of the Medicaid client:

- The right to receive dental services that meet or exceed the standards of care established by the laws relating to the practice of denistry and the rules and regulations of the TSBDE
- The right to receive information following a dental examination regarding the dental diagnosis; scope of proposed treatment, including alternatives and risks; anticipated results; and the need for administration of sedation or anesthesia, including risks
- The right to full participation in the development of the treatment plan and the process of giving informed consent
- The right to freedom from physical, mental, emotional, sexual, or verbal abuse or harm from the provider or his/her staff
- The right to freedom from overly aggressive treatment in excess of that required to address documented medical necessity

Important: A provider's failure to ensure any of the client rights may result in termination of the provider agreement or contract and other civil or criminal remedies.

3.5 Written Informed Consent and Standards of Care

Only THSteps clients or their parents or legal guardians can give written informed consent. THSteps clients or their parents or legal guardians who can give written informed consent must receive information following an oral evaluation about the dental diagnosis, scope of proposed treatment, including alternatives and risks, anticipated results, and need for administration of sedation or anesthesia, including risks. Additionally, they must receive a full explanation of the treatment plan and give written informed consent before implementation. Parental or guardian accompaniment of the client to the dental visit facilitates the provider obtaining written informed consent. Dentists must comply with TSBDE Rule 109.122, "Special Knowledge."

Important: All standards of care must be adhered to per TSBDE rules.

3.6 Periodicity for Scheduled Preventive Dental Services

The provider determines if the client is Medicaid eligible on the day services are to be provided. The client Medicaid Identification (Form 3087) indicates to the provider the eligibility status of the client for Medicaid services for a specific month. The card also reminds the client that he or she is eligible for a periodic dental checkup that month.

If the dental checkup is not conducted during the month that it is due, the client remains eligible for the periodic dental checkup in the following months until one is conducted. If the reminder of the periodic dental checkup does not appear on the card for a particular month, the client still is entitled to other covered dental services.

In some cases, the client may be eligible to receive another periodic dental checkup within the same six-month period that the previous one was conducted. If the client requests a second opinion, or if the client changes providers, he or she is eligible to receive a periodic dental checkup.

The dental provider may perform any necessary dental service that is within the Texas Medicaid Program's guidelines and limitations.

A narrative explaining the reason for the exception to periodicity limitations must be included on the claim, whether electronic or paper. The exception must be indicated in the appropriate block whether filing a paper claim or electronically. Documentation must be kept in the client's file.

For THSteps clients, exceptions to the periodicity schedule for dental services may be approved for one of the following reasons:

- Medically necessary service, based on risk factors and health needs (includes clients younger than 12 months)
- Service is required to meet federal/state exam requirements for Head Start, day care, foster care, or preadoption
- Client chooses to change service providers (not applicable to referrals)
- Subsequent therapeutic services are necessary to complete a case for clients younger than 12 months when initiated as emergency services

The periodicity schedule for preventative dental procedures (prophylaxis, fluoride, radiographs, and exams) does not apply for Intermediate Care Facility for the Mentally Retarded (ICF-MR) clients age 21 years and older.

3.7 Parental Accompaniment

As a condition for provider reimbursement, as required by Section 32.024(s) – (s-1) of the Human Resources Code, a child younger than age 15 must be accompanied by the child's parent, guardian, or other authorized adult at dental visits and screenings under the state Medicaid program.

Exception: School health clinics, Head Start programs, and child-care facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement and obtains written consent for the services. The consent from the child's parent or guardian must have been received within the one-year period before the date the services are provided and must not have been revoked.

Providers will not be required to submit documentation to TMHP to verify compliance with this policy for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

3.8 Dental Assessment Guidelines for THSteps Medical Providers

The following information provides guidelines for THSteps medical providers in performing the initial dental screening as required in a comprehensive THSteps medical checkup.

The applicable periodicity schedule for THSteps dental assessment follows the standards as adopted by the American Academy of Pediatric Dentistry. The initial dental assessment by the medical provider, as required within the comprehensive THSteps medical checkup, should occur at 12 months of age or when first teeth have erupted, and each medical checkup visit thereafter. The medical checkup must initiate the referral for the more comprehensive THSteps Dental Exam by a THSteps participating dentist, starting at age one and every six months thereafter (unless unusual circumstances dictate more frequent referrals). Eruption pattern evaluation by the medical provider can be a valuable diagnostic tool. A delayed eruption pattern of 6-12 months should be evaluated by the medical provider for potential medical/nutrition etiology. An eruption pattern and sequence chart is located in the "Development of Human Dentition Chart" on page 54.

Baby Bottle Tooth Decay (BBTD). To reduce the risk of Baby Bottle Tooth Decay (BBTD) the parent/guardian should always be counseled in proper feeding practices including:

- Never put a child to bed with a bottle containing any liquid other than water
- Recommendations on the decreased frequency and duration of bottle feeding
- Bottle contents (water is recommended in the bottle other than at regular feeding times)

- Feedings should be followed by gentle cleansing of the oral structures with a clean, damp cloth or soft brush
- Establish goal to have the child drinking from a cup at 6 months of age

Early signs of BBTD often present as chalky white spots, particularly on the lingual surfaces of Maxillary incisors. These signs, or any indication of more advanced caries, should prompt an immediate referral to appropriate dental care providers for evaluation.

Primary Teeth. The 20 primary teeth are also called deciduous teeth or baby teeth. Besides functioning in mastication, they also serve roles in speech development, jaw development, and eventually in the position of the permanent dentition. Premature loss of the primary teeth can lead to permanent space loss within the dental arch and significant problems with alignment and function of the permanent teeth. If a primary tooth is lost prematurely, it is important for the patient to be evaluated within the next few weeks by a dentist, and a determination made a for space supervision. Delayed exfoliation of the primary teeth may also have a harmful effect on the permanent dentition and calls for a dental evaluation.

Permanent Teeth. The first permanent tooth is the six-year molar, which is the sixth tooth from the mid-line between the central incisors. There are four of them, and they erupt when a child is between ages 5 and 6. The first permanent molar is often mistaken for a primary tooth because no tooth is lost. These teeth are termed the keystones of the dental arches because they help guide the subsequent teeth into proper alignment.

Caries. Children with developing primary or mixed (primary-permanent) dentition should be evaluated for caries.

Oral Soft Tissues. Oral soft tissues should be examined for any abnormalities. Consultation with a dental provider, where a differential diagnosis may apply, is highly recommended.

Sealants. Many studies have shown that dental sealants can protect the tooth from decay when properly applied.

Adolescent Dental Assessment. Evaluate the following:

- Dental eruption pattern
- Decay prevalence
- Oral hygiene practice
- Oral soft tissue status

Soft tissue irritants in adolescents often precipitate amplified tissue responses. Diabetic patients or children receiving long term medications are particularly at risk. These patients will benefit from education in the necessity of good oral hygiene practices.

Patient Dental Education. This education should include:

- The need for thorough daily oral hygiene practices
- Education in potential gingival manifestations for patients with diabetes and patients under long-term medications therapy
- Utilization of the THSteps eligibility for dental services

Smokeless Tobacco. The use of smokeless tobacco is expanding in many population groups, and is strongly correlated with an increase in the prevalence of oral cancer. Early intervention and education can play a significant role in reducing the following risks:

- Assess patterns of use
- Offer assistance in cessation, if appropriate
- Evaluate oral hard and soft tissues particularly the muccobuccal folds, cheeks and sublingual areas
- Refer all suspected lesions to appropriate providers for evaluation and follow up

Referral Assistance. Assistance in coordinating the referral can be obtained from the TMHP Hotline (800-568-2460), or TDH Regional THSteps Coordinator for the respective region (the lists are provided in the "Communication Guide" on page A-1 of the *Texas Medicaid Provider Procedures Manual*).

Dental Disease Prevention. Perhaps the two most important interventions are:

- Early and periodic dental examinations
- Parent education that stresses to parents the important role they can play in preventing dental disease in their children

Regularly positioned teeth with normal occlusion add symmetry and harmony to the facial appearance and are an important aspect of the expression of emotion and personality.

THSteps Dental Services. THSteps dental services are mandated by Medicaid and provide reimbursement for the early detection and treatment of dental health problems for Medicaid-eligible clients younger than age 21. THSteps dental service standards were designed to meet federal regulations and to incorporate the recommendations of representatives of dental professional groups in the state.

Refer to: "THSteps-Comprehensive Care Program (THSteps-CCP)" on page 40-20 of the *Texas Medicaid Provider Procedures Manual* for more information.

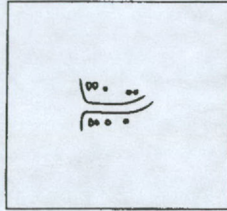
Follow-up Dental Care and Referrals

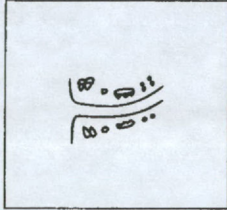
If a THSteps dental checkup reveals a dental health condition that requires follow-up diagnoses or treatment, the provider performing the dental checkup should assist the client in planning follow-up care or in making a referral to the qualified provider. The *Texas Medicaid Provider Procedures Manual* provides information regarding covered benefits, assistance to identify qualified providers, and on coding and billing for services covered by the THSteps program, THSteps-CCP, or traditional Medicaid program.

For service delivery areas where the Medicaid-eligible client is enrolled in a HMO, the dental care will be provided by a Medicaid enrolled dentist (fee-for-service); however, nondental, adjunct providers, such as the facility and anesthesiology care, must be HMO network providers or previously approved by the HMO.

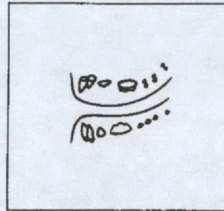
3.9 Development of Human Dentition Chart

Prenatal

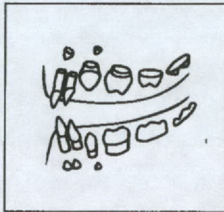

4 months in utero

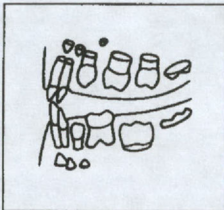

6 months in utero

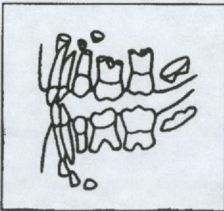
Infancy


Birth

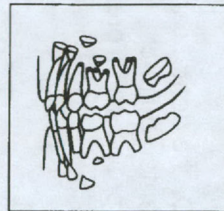
4-8 months

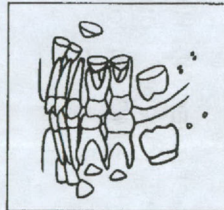

8-12 months

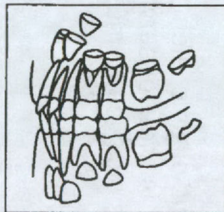

9-15 months

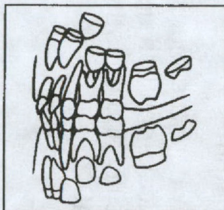

15-21 months

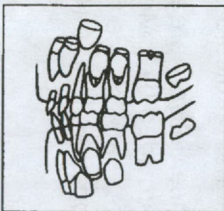
Early Childhood


18-30 months

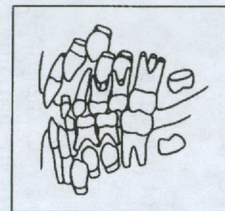

2-3 years

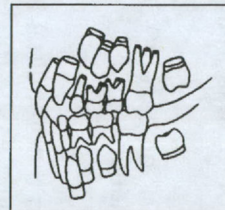

3-4 years

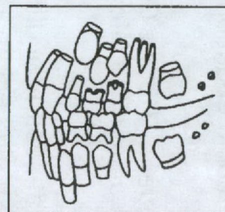

4-5 years

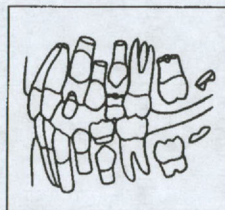

5-6 years

Late Childhood

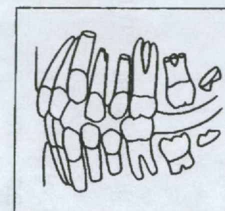

6-7 years

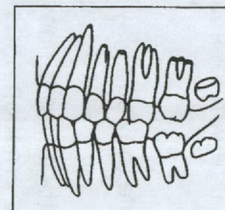

7-8 years

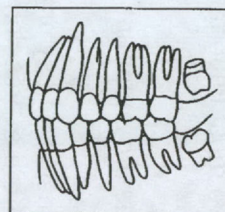

8-9 years

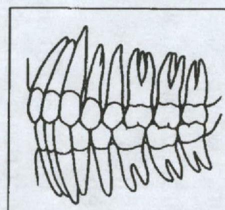

9-10 years

Adolescence and Adulthood


10-11 years


11-12 years


14-15 years


21 years

☐ **Primary Dentition**

☐ **Permanent Dentition**

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Immunizations

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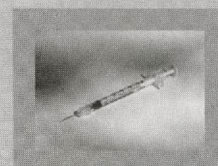
4.1 Immunizations Overview

Children must be immunized according to the Recommended Childhood Immunization Schedule for the United States. The checkup provider is responsible for the administration of immunizations and may not refer children to local health departments. The Texas Department of Health (TDH) requires that immunizations be administered during the THSteps medical checkup, unless they are medically contraindicated or exclusions from immunizations for reasons of conscience, including a religious belief.

A $5 administration fee is paid for immunizations given during a THSteps checkup or as part of a follow-up visit. THSteps providers should bill for each vaccine separately. Combined antigens, such as diphtheria, tetanus, and pertussis vaccine (DTaP), count as one dose.

Providers, both in the public and private sector, are required by federal mandate to provide a Vaccine Information Statement (VIS) to the responsible adult accompanying a child for an immunization. These statements are specific to each vaccine and inform the responsible adult about the risks and benefits. It is important that providers use the most current VIS.

Providers interested in obtaining copies of current statements and other immunization forms or literature may call the TDH Immunization Division at 800-252-9152 or 512-458-7284. Vaccine Information Statements may also be downloaded from the TDH Immunization Division Web site at
www.tdh.state.tx.us/immunize/vischart.htm.



4.1.1 Exclusions from Immunizations for Reasons of Conscience, Including a Religious Belief

Immunization is not required for a child's admission to any elementary or secondary school if the child's parent or guardian presents a signed affidavit stating that the applicant declines immunization for reasons of conscience, including a religious belief. A child who has not received the required immunizations due to reasons of conscience may be excluded from school in times of emergency or epidemic declared by the commissioner of public health. The affidavit will be valid for a five (5) year period. A person declining a required immunization for a child may only obtain the affidavit form by submitting a written request for the affidavit form to the Texas Department of Health (TDH). The request must include the child's name and date of birth (month/day/year). The written request must be submitted through the U.S. Postal service, common carrier, or by hand delivery to the TDH Bureau of Immunization and Pharmacy Support.

Additional information is available from the TDH Immunization Web site, http://www.tdh.state.tx.us/immunize/school_exclusion.htm#conexempt.

4.2 Recommended Childhood Immunization Schedule

The Recommended Childhood Immunization Schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. It is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Some combination vaccines are available and may be used when any component of the combination is indicated and its other components are not contraindicated. Providers should consult the manufacturers' package insert for detailed recommendations.

Vaccines are routinely listed under recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Note: ACIP issued the following statement concerning rotavirus vaccine on October 22, 1999: "The Advisory Committee on Immunization Practices (ACIP) recommended today that Rotashield, the only U.S.-licensed rotavirus vaccine, no longer be recommended for infants in the United States."

4.2.1 Recommended Childhood Immunization Schedule–United States, 2003

range of recommended ages | catch-up vaccinations | preadolescent assessment

Vaccine ↓ / Age →	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	13-18 yrs
Hepatitis B[1]	HepB #1 only if mother HBsAg (-)										HepB series	
			HepB #2			HepB #3						
Diphtheria, Tetanus, Pertussis[2]			DTap	DTaP	DTaP		DTaP			DTaP	Td	
Haemophilus influenzae Type b[3]			Hib	Hib	Hib	Hib						
Inactivated Polio			IPV	IPV		IPV				IPV		
Measles, Mumps, Rubella[4]						MMR #1				MMR#2	MMR #2	
Varicella[5]							Varicella				Varicella	
Pneumococcal[6]			PCV	PCV	PCV	PCV			PCV		PPV	
Vaccines below this line are for selected populations												
Hepatitis A[7]											Hepatitis A series	
Influenza[8]									Influenza (yearly)			

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2002, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible. ▬ Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contradindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

Footnotes

Recommended Childhood and Adolescent Immunization Schedule— United States, 2003

1. Hepatits B vaccine (HepB). All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administereed when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months. These infants should be tested for HBsAg and anti-HBs at 9-15 months of age.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1-2 months. The last dose in the vaccination series should not be administered before age 6 months.

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. **Tetanus and diphtheria toxoids (Td)** is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children, i.e. those who lack a reliable history of chickenpox. Susceptible persons aged $\geq$ 13 years should receive two doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. **Pneumococcal polysaccharide vaccine (PPV)** is recommended in addition to PCV for certain high-risk groups. See *MMWR* 2000;49(RR-9);1-38.

7. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions, and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high risk groups who have not been immunized against hepatitis A can begin the hepatitis A vaccination series during any visit. The two doses in the series should be administered at least 6 months apart. See *MMWR* 1999;48(RR-12);1-37.

8. Influenza vaccine. Influenza vaccine is recommended annually for children age $\geq$6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes, and household members of persons in groups at high risk; see *MMWR* 2002;51(RR-3);1-31), and can be administered to all others wishing to obtain immunity. In addition, healthy children age 6-23 months are encouraged to receive influenza vaccine if feasible because children in this group are at substantially increased risk for influenza-related hospitalizations. Children aged $\leq$12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if aged $\geq$3 years). Children aged $\leq$8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

Approved by the Advisory Committee on Immunization Practices (www.cdc.gov/nip/acip), the American Academy of Pediatrics (www.aap.org), and the American Academy of Family Physicians (www.aafp.org).

The TVFC program can now provide Hepatitis B vaccine to THSteps children from birth through 18 years of age. TVFC vaccine may also be used to complete the series if the child is under age 19 when beginning the series.

Providers must purchase a private supply of Hepatitis B Vaccine for THSteps clients who are age 19 or older and who are beginning the Hepatitis B vaccination series.

Important: The Texas Health and Safety Code (§81.090) requires all pregnant women to be screened for Hepatitis B virus (HBV) infection at their first prenatal examination and at delivery. Reporting of HBsAg-positive test results obtained through prenatal screenings have been added to the list of notifiable diseases in Texas.

There is no change in the protocol for management of newborns with perinatal exposure – newborns whose mothers are Hepatitis B Surface Antigen (HBsAg) positive. All pregnant women should be screened for HBsAg as early as possible in their pregnancy. Asymptomatic HBsAg positive women, with or without pertinent hepatitis history, should be referred immediately to the nearest local health department or TDH Regional Immunization Program office for contact screening, immunizations, and for immunotherapy for the newborn. You may call the TDH Perinatal Hepatitis B Coordinator at 800-252-9152 or 512-458-7284 for a referral to a nurse to help with follow-up of high-risk infants and children.

Neonates with perinatal exposure require timely immune therapy consisting of 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of delivery or within seven days postpartum and the correct dose of hepatitis B vaccine for a high-risk infant.

Refer to: "Recommended Childhood Immunization Schedule–United States, 2003" on page 57.

4.3 General Recommendations

For information about vaccine administration, dosing, and contraindications, immunization providers should consult vaccine package inserts and the February 8, 2002 issue of the *Morbidity and Mortality Weekly Report (MMWR), General Recommendations on Immunization, Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. For copies of the General Recommendations on Immunization or the MMWR, contact the Immunization Division at 512-458-7284 or 800-252-9152.

4.3.1 Hepatitis A

For 32 counties along the Texas-Mexico border, and an additional 24 Texas counties, the Hepatitis A vaccine is now a routinely recommended vaccine. The TVFC Program provides Hepatitis A vaccine for eligible children 2 through 18 years of age who reside or attend school or child care facilities in the 56-county area. Children 2 through 12 years of age should be specifically targeted. All American Indian and Alaskan Native children age 2 years through 18 years of age residing or presenting for immunization services in Texas, are eligible, regardless of residency.

The affected counties are Bexar, Brewster, Brooks, Cameron, Comal, Crockett, Culberson, Dallas, Dimmit, Duval, Ector, Edwards, El Paso, Frio, Galveston, Grayson, Gregg, Guadalupe, Hale, Harris, Hays, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Johnson, Kenedy, Kinney, Kleberg, La Salle, Maverick, McLennan, McMullen, Midland, Moore, Nueces, Pecos, Potter, Presidio, Randall, Real, Reeves, Smith, Starr, Sutton, Tarrant, Terrell, Terry, Tom Green, Travis, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

For all other counties in Texas, Hepatitis A is not a routine childhood vaccine. The vaccine is provided based on medical necessity and the documented need of the community. Providers should contact their regional or local health department to find out if they are in areas with documented need for the vaccine.

The Hepatitis A vaccine will be readily available to TVFC providers. Additional information on vaccine storage, route of administration, vaccination schedule, dosage, vaccine efficacy, side effects, and adverse events is available in the CDC document *Prevention of Hepatitis A Through Active or Passive Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* online at: www.cdc.gov/mmwr/preview/mmwrhtml/rr4812a1.htm.

4.3.2 How to Obtain Free Vaccines

TDH provides vaccines for immunization of THSteps patients free of charge to THSteps medical checkup providers and other qualified Medicaid providers through the local health department/district and regional offices of TDH. The local health department/district or TDH regional office provides information on how to order, account for, and inventory vaccines. If the requested reports are not received monthly, the provider will not be supplied with state-purchased vaccines. Physicians who request and accept state-supplied vaccines must annually complete and sign the provider enrollment and profile forms.

4.3.3 Provider Immunization Reimbursement Fee

THSteps and other qualified providers may be reimbursed $5 for each dose of vaccine administered during a THSteps medical screen, adolescent screen, or a follow-up visit. Combined antigen vaccines (DTaP, Hib, MMR) are reimbursed as one dose.

4.3.4 Instructions

By enrolling, public and private providers agree to:

1) Sign for each order of vaccine:
    - Public health regions and local health departments/districts may be exempt from signing individual vaccine orders
    - Biological Order Form (Form C-68) may be used to order vaccine
2) Complete a Summary Sheet for Immunizations (Form C-5) each month for the doses of vaccine administered by age group.
3) Complete the Monthly Vaccine Report (Form C-33) each month making certain that monthly waste and loss of state and federally funded vaccine are in the explanation section of the report (list vaccines by vaccine category, vaccine lot number, and vaccination expiration date); excessive waste with no attempt to return short-dated vaccine will be sufficient grounds to terminate this agreement.
4) Twice daily, monitor and record refrigerator and freezer temperatures on the Temperature Recording Form (C-105).
5) Use Vaccine Information Statements (VIS). Public and private clinics should have the patient, parent, guardian, or responsible adult read the appropriate VIS.
6) Not charge patients for vaccines provided by the health department.

4.3.5 Billing Instructions

Routine immunizations administered during a THSteps medical checkup or follow-up visit should be billed using the provider's THSteps Texas Provider Identifier (TPI). If administered outside of a THSteps medical checkup or follow-up visit, use the provider's regular Medicaid TPI.

Texas law requires medical providers to report immunization information to the Texas Department of Health (TDH) for children whose parent or guardian **has consented in writing** to participation in the statewide immunization registry, *ImmTrac*.

ImmTrac is a centralized repository of immunization histories for children younger than age 18 years. The *ImmTrac* registry is a free service available to all Texas children and benefits all Texans. Registry information is confidential and by law may only be released to a parent or legal guardian to the child, the child's physician, the school or licensed child-care facility in which the child is enrolled, and public health districts or local health departments. The registry is operated by TDH.

The Texas Health and Safety Code (§ 161.007-161.009) states that effective January 1, 1999, with the **written consent** of the parent or guardian, all immunizations administered to children between the ages of 0–18 years must be reported to *ImmTrac* within 30 days of administration. When a parent gives written consent to include their child's information in *ImmTrac*, the consent applies to all "past, present, and future" immunizations.

Medicaid providers must communicate consent for *ImmTrac* participation to TMHP when billing for immunizations. After processing claims, TMHP forwards all consented immunization records directly to *ImmTrac*. U6 is the modifier used to indicate consent for *ImmTrac* Registry participation. **A claim will not deny if the U6 modifier is not on the claim; however, consented immunization records will not be reported to *ImmTrac*.**

Due to changes required by the federal *Health Insurance Portability and Accountability Act of 1996* (HIPAA), effective October 16, 2003, the *ImmTrac* consent modifier changed from **NC** to **U6**. Providers should enter modifier U6 after every vaccine procedure code, but not after the administration codes 90471 and 90472.

4.3.5.1 How to Report Written Consented Immunization Records via Medicaid Billing

The following options exist for communicating *ImmTrac* consent:

1) If filing paper claims using form HCFA-1500, communicate consent in section 24D by adding "U6" in the modifier field corresponding to each administered immunization being billed.
2) If submitting electronic billing using TDHconnect or any other X.12 4010 format, communicate consent for ImmTrac by adding "U6" to the detail portion of the claim, next to the procedure code.

Use the following immunization procedure codes when billing a THsteps medical checkup on the HCFA-1500 claim form. Each vaccine administration code must be matched with the appropriate vaccine code.

Diagnosis code V202 is required to be used with the following procedure codes:

Procedure Code	Description
90632	Hepatitis A vaccine, adult dosage, for intramuscular use
90633	Hepatitis A vaccine, pediatric/adolescent dosage (2-dose schedule), for intramuscular use
90645	Hemophilus Influenza B vaccine (HIB), HBOC conjugate (4 dose schedule), for intramuscular use
90646	Hemophilus Influenza B vaccine (HIB), PRP-D conjugate, for booster use only, intramuscular use
90647	Hemophilus Influenza B vaccine (HIB), PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	Hemophilus Influenza B vaccine (HIB), PRP-T conjugate (4 dose schedule), for intramuscular use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under five years, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTAP), for intramuscular use
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP), for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed for use in individuals younger than seven years, for intramuscular use
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use
90712	Poliovirus vaccine, (any type[s]) (OPV), live, for oral use
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use

Procedure Code	Description
90716	Varicella virus vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (TD) adsorbed for use in individuals seven years or older, for intramuscular or jet injection
90720	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and hemophilus influenza B vaccine (DTP-HIB), for intramuscular use
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use

Refer to: "Texas Health Steps (THSteps)" on page 40-1 of the *Texas Medicaid Provider Procedures Manual.*

4.4 Texas Vaccines for Children Program Packet (9 Pages)

Texas Vaccines for Children Program

Questions and Answers

1

Texas Vaccines for Children Program

1) Question: What is the Texas Vaccines for Children Program?

Answer: This is a federally funded, state-operated vaccine distribution program.

Children Who Qualify

2) Question: Which children qualify for free vaccines?

Answer: All children are eligible for free vaccines except children:
(1) with insurance that pays for immunization services, and
(2) whose parents or guardians are able to pay for immunization services

Underinsured Children

3) Question: What about children with insurance that doesn't include vaccination as a covered benefit? Are they eligible to receive free vaccine?

Answer: Yes, they are eligible. Children who fall into this category may only be given PCV-7 at an FQHC or RHC.

Vaccine-Related Fees

4) Question: Why are there fee caps on what providers can charge to administer the vaccine?

Answer: Federal legislation requires fee caps for administration on a nationwide basis that balance the provider's financial need and the patient's ability to pay. The fee cap for Texas is $14.85 per vaccine.

Texas Vaccines for Children Program

Questions and Answers

2

5) Question: Will the Texas Medicaid Program reimburse private practitioners for vaccines administered to Medicaid patients?

Answer: Yes. The Texas Medicaid vaccine administration fee is $5.00 per administered vaccine dose.

Medicaid Enrollment

6) Question: To participate in the Texas Vaccines for Children Program, must providers enroll as a state Medicaid provider?

Answer: No. However, if you are enrolled in the state Medicaid Program, you must register in the Texas Vaccines for Children Program to receive free vaccines.

Why Register?

7) Question: Why should a health care provider enroll in the Texas Vaccines for Children Program?

Answer: You can get free vaccines for your eligible patients.
You will not need to refer patients to public clinics for vaccines.
You can provide immunizations to your patients as part of a comprehensive care package – this will enhance the opportunity for patients to find a medical home.

Patients served

8) Question: Once enrolled, are providers required to immunize children who are not their patients?

Answer: No. You control who you see in your practice.

Texas Vaccines for Children Program

Questions and Answers

3

9) Question: Why must providers complete a Provider Profile describing patients by eligibility category?

Answer: It is a federal requirement. It also allows TDH to determine how the cost of vaccines will be divided among state and federal funds. After a year, you may find your profile information has changed. The Provider Profile must be updated annually.

Vaccine Ordering and Supply

10) Question: Can providers choose a specific manufacturer's vaccine and always receive it?

Answer: No. TDH would like to allow for provider preference, but we will not be able to guarantee first choice on all orders. However, we will try and minimize differences.

11) Question: How will I order vaccines that I need for my eligible patients?

Answer: Providers will order vaccines through their public health region.

12) Question: It is difficult to distinguish between patients who are fully insured from Texas Vaccines for Children Program eligible patients. Why must I order their vaccine separately?

Answer: Children whose insurance includes immunizations and patients who are able to pay for the vaccines are not eligible to receive free vaccine through the Texas Vaccines for Children Program.

Texas Vaccines for Children Program

Questions and Answers

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Duty to Warn Unchanged

13) Question: Will providers be required to increase the amount of Vaccine Information Materials they provide to parents because of the Texas Vaccines for Children Program?

Answer: No. Materials required of all providers through the National Childhood Vaccine Injury Act are sufficient.

Eligibility Status

14) Question: Must providers ask the patient's eligibility status each time the patient comes for the vaccine visit?

Answer: No. Providers need only update eligibility status whenever there is reason to believe a child's eligibility status has changed.

15) Question: How are providers expected to verify responses for vaccine eligibility?

Answer: Providers are not expected to do anything more than ask the parent what the child's eligibility status is and then record the response. The parent can complete the Vaccine Eligibility Screening Form.

REQUIREMENTS FOR THE TEXAS VACCINES FOR CHILDREN PROGRAM

INSTRUCTIONS:

The private physician, public health region, local health department/district, community/migrant rural health clinic, or other organization that qualifies for Texas Vaccines for Children Program agrees to:

1. Sign for each order of vaccine:

   (a) Public health regions and local health departments/districts may be exempt from signing individual vaccine orders.

   (b) Biological Order Form (Form C-68) routinely should be used to order vaccines.

2. Complete a Summary Sheet for Immunizations (Form C-5) each month for the doses of vaccine administered by age group.

3. Complete the Monthly Vaccine Report (Form C-33) making certain that monthly waste and loss of State and federally funded vaccines are in the explanation section of the report (vaccines must be listed by vaccine category, vaccine lot number, and vaccination expiration date); excessive waste with no attempt to return short-dated vaccine will be sufficient grounds to terminate this agreement.

4. Monitor and record refrigerator and freezer temperatures twice daily on the Temperature Recording Form (C-105).

5. Use Vaccine Information Statements: Public and private clinics should have the patient, parent, guardian, or responsible adult:

   (a) Read the appropriate Vaccine Information Statements and sign the consent form each time an immunization is administered, or

   (b) Read the appropriate Vaccine Information Statements and sign the Vaccine Information Documentation Form (Form C-100) each time an immunization is administered.

6. Comply with the requirements of the National Childhood Vaccine Injury Act.

   The provider must record, either on the patient's permanent medical record, the Vaccine Information Statements, or the Vaccine Information Documentation Form, the information listed below:

   ✓ Date vaccine is administered
   ✓ Manufacturer's name and lot number of the vaccine
   ✓ Site of injection
   ✓ Signature of person administering the vaccine
   ✓ Professional title of person administering the vaccine
   ✓ Address of the facility in which the vaccine is administered
   ✓ Edition date of VIS and date provided

TDH

TEXAS VACCINES FOR CHILDREN PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

Purpose: To determine eligibility and the source of funds for the Texas Department of Health to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger, who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: ____________________

Child's Name: ____
Last Name First Name MI

Child's Date of Birth: ______/______/______

Parent/Guardian/
Individual of Record: ____
Last Name First Name MI

Provider's Name: ____

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check 1st category that applies, check only one)*:

☐ (a) is enrolled in Medicaid or

☐ (b) does not have health insurance or

☐ (c) is an American Indian or

☐ (d) is an Alaskan Native or

☐ (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage) or

☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria or

☐ (g) CHIP: is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)

***Pneumococcal conjugate vaccine may be administered in all TVFC-enrolled clinic sites to children in Categories a, b, c, d, and g only. This vaccine can only be given to children in Category e who have health insurance that does not pay for vaccine AND present for services in a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic.**

Texas Immunization Registry-ImmTrac Consent

The following is OPTIONAL. Checking "NO" will have NO EFFECT ON your child's eligibility to receive immunizations.

I authorize the placement of my child's demographic information and immunization record into the Texas Department of Health's Immunization Registry. I authorize the Texas Department of Health's Immunization Registry to release past, present, and future immunization records on my child to a parent of the child and any of the following: A) public health district; B) local health department; C) physician to the child; D) school in which the child is enrolled; and/or E) child care facility in which the child is enrolled. I understand that I may withdraw the consent to place information on my child in the immunization registry and my consent to release information from the registry at any time by written communication to the Texas Department of Health, Immunization Registry, 1100 W. 49th Street, Austin, Texas, 78756. **Only a parent, legal guardian, or managing conservator may give consent for tracking. To give or deny consent for tracking only, check appropriate box below.**

☐ **YES,** I give consent to place my child in the immunization registry.

☐ **NO,** I do **NOT** give consent to place my child in the immunization registry.

____
(Signature of Parent/Guardian/Legal Conservator)

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TDH

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

☐ Initial enrollment * ☐ Re-enrollment   Provider PIN Number ___ ___ ___ ___ ___ ___

*Contact the PHR in your area to obtain PIN

Name of Facility, Practice, or Clinic: ______________________________

Provider Name (M.D., D.O., N.P., P.A. or C.N.M.*): ______________________________
(Last Name) (First Name) (MI) (Title)

Contact: ______________________________
(Last Name) (First Name) (MI) (Title)

Mailing Address: ______________________________
(P.OBox or Street Address) (City) (Zip)

Address for Vaccine Delivery: ______________________________
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (_____)_____-_____   Fax Number: (_____)_____-_____

E-mail Address: ______________________________

In order to participate in the Texas Vaccines for Children Program and/or to receive federally and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

1) Before administering vaccines obtained through the Texas Vaccines for Children Program (TVFC), my office will determine VFC eligibility. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.
2) My office will maintain records of the parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If I use the Patient Eligibility Screening form as the sole source of documenting ImmTrac consent, I will maintain this record until the child has reached his/her 19th birthday. If requested, my office will make such records available to the Texas Department of Health (TDH), the local health department/authority or the U.S. Department of Health and Human Services.
3) My office will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, my office deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.
4) My office will provide Vaccine Information Statements to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. (Signatures are not required for the Vaccine Information Statements but are recommended.)
5) My office will not charge for vaccines supplied by TDH and administered to a child who is eligible for the TVFC.
6) My office may charge a vaccine administration fee. My office will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by TDH. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.
7) My office will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
8) My office will comply with the State's requirements for ordering vaccine and other requirements as described by TDH.
9) My office or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.
10) My office will allow TDH (or its contractors) to conduct on-site visits as required by VFC regulations.

______________________________   ______________________________
(Signature*)   (Date)

*The TVFC Enrollment form must be signed by a licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife.

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TDH

TEXAS VACCINES FOR CHILDREN PROGRAM
PROVIDER PROFILE FOR PIN ___ ___ ___ ___ ___ ___

Is your facility a Federally Qualified Health Center, Migrant Health Clinic, or Rural Health Clinic?
(circle one) YES NO

Type of Clinic: (√ check one)

- ☐ Public Health Department/District
- ☐ Private Hospital
- ☐ Public Hospital
- ☐ Private Practice (Individual or Group)
- ☐ Other Public Clinic
- ☐ Other Private Clinic

PATIENT PROFILE:

Please enter the number of children for each of the following categories and by age group who will be vaccinated at your clinic in the next 12 month period.

NUMBER OF CHILDREN IN EACH CATEGORY	< 1 year old	1-6 years	7-18 years	Total
Enrolled in Medicaid.				
Uninsured. *(Note: Children enrolled in Health Maintenance Organizations are considered insured)*				
American Indians.				
Alaskan Natives.				
Underinsured. (Has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)				
(For Public Health Clinic Use ONLY) Children who do not meet any of the above criteria, but still receive vaccinations at **public health clinics.**				
Children who receive benefits from the Children's Health Insurance Plan (CHIP).				
Children who are vaccinated in your practice, but are **NOT** TVFC-eligible.				
TOTAL PATIENTS: (Add columns)				

TDH

TEXAS VACCINES FOR CHILDREN PROGRAM
PROVIDER LIST

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (list provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	Texas Provider Identification	Medical License Number	Speciality (Family Medicine, Pediatrics, etc.)

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TEXAS VACCINES FOR CHILDREN PROGRAM
Provider List-Addendum for PIN ___ ___ ___ ___ ___ ___

Please list all individuals within the practice who will be administering TVFC supplied vaccine.

Last Name (list provider who signed Provider Enrollment Form first)	First Name	Middle Initial	Title (M.D., D.O., N.P., P.A., R.N., L.V.N., M.A.)	Texas Provider Identification	Medical License Number	Speciality (Family Medicine, Pediatrics, etc.)

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HIV/AIDS

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5.1 Model Workplace Guidelines for Businesses, State Agencies, and State Contractors

5.1.1 Purpose

To protect employment rights and privileges of individuals infected with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) through compliance with federal, state, and local laws. This policy will provide Texas employers, especially state agencies, with a uniform approach to developing policies and education programs that address HIV/AIDS in the workplace. The Texas Department of Health (TDH) encourages all employers to establish workplace policies concerning persons with HIV/AIDS. Employers can adapt this model to fit the particular needs of their organization, work force, and clients. However, the content and intent must remain consistent with this document and the Texas Health and Safety Code.

5.1.2 Authority

Governance for this policy is found in *Vernon's Texas Codes Annotated*, Health & Safety Code (HSC) §85.010, "Educational Course for Employees and Clients of Health Care Facilities"; §85.111, "Education of State Employees"; §85.112, "Workplace Guidelines"; and §85.113, "Workplace Guidelines for State Contractors."

The model workplace guidelines developed by TDH, Bureau of HIV and STD Prevention, as required by HSC §85.012, "Model Workplace Guidelines"; and adopted as HIV/STD Policy No. 090.021, are considered the minimum standards for the development of guidelines for state agencies. This policy also serves as the minimum standard for contractors of 10 designated state agencies and organizations funded by the 10 designated state agencies.

These guidelines are also the standard for health care facilities licensed by TDH, the Texas Department of Mental Health and Mental Retardation, and the Texas Department of Human Services, as stated in HSC §85.113, "Workplace Guidelines for State Contractors."

Refer to: "State Agencies Listed Under HSC §85.113" on page 77.

5.1.3 Who Must Use Workplace Guidelines

5.1.3.1 State Agencies

State law requires that each state agency adopt and carry out workplace guidelines. The agency's workplace guidelines should at least include the TDH model workplace guidelines.

5.1.3.2 State Contractors

A program involving direct client contact, which contracts with or is funded by any of the state agencies listed in "State Agencies Listed Under HSC §85.113" on page 77, will adopt and carry out workplace guidelines as stated in HSC §85.113.

5.1.4 Why Have Guidelines

Employers should develop and carry out policies and education programs concerning potentially limiting medical conditions before a crisis arises. Such policies and education programs help reduce employees' fears and misconceptions about HIV/AIDS and help to accomplish the following:

- Provide current and accurate scientific evidence that people with HIV infection do not pose a risk of transmitting the virus to coworkers through ordinary workplace contact
- Provide workers with current information about HIV risk reduction for employees and their families
- Avoid conflict between the infected employee and the employer regarding discrimination or other employment issues
- Prevent work disruption and rejection of the infected employee by coworkers
- Inform employees that they have rights regarding work continuation, confidentiality of medical and insurance records, and general health and safety
- Provide specific and ongoing education and equipment to employees in health care settings who are at risk of HIV exposure, and to assure appropriate infection-control procedures are used
- Reduce the workplace's financial impact, legal implications, and other effects of HIV/AIDS

5.1.5 Development of Workplace Policy Content

Individuals infected with HIV have the same rights and opportunities as other individuals. While some employers prefer a policy specific to HIV/AIDS and its unique issues, others prefer a general policy concerning illnesses and disabilities. A general policy should address HIV/AIDS in the same way as other major illnesses. We encourage use of the following statements in agency policy:

- Use of a person's HIV status to decide employment status, service delivery, or to deny services to HIV-infected individuals is unacceptable. Employees who feel they have been discriminated against because of HIV or AIDS should contact the personnel office to discuss the matter, or initiate action through the agency's grievance procedure. Other legal options may be available.
- This policy is consistent with current information from public health authorities, such as the Centers for Disease Control and Prevention (CDC) of the United States Public Health Service, and with state and federal laws and regulations.

While the approach and resolution of each employee's situation may vary, similar issues may arise. A workplace policy should address the following issues about HIV/AIDS and other life-threatening illnesses or disabilities:

- **Discrimination.** The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination against people with disabilities, which include HIV and AIDS, in employment, public accommodations, public transportation, and other situations. A specific policy statement that no one will be denied employment or employment opportunities because of a disability, satisfies the employer and employee's need to address discrimination. For example, "This agency complies with the ADA protections of all people with disabilities against discrimination in job application procedures, hiring, promotions, discharge, compensation, job training, and other terms or employment conditions." Managers should define how they will deal with discriminatory actions.
- **Desire and Ability to Work.** A workplace policy should address infected employees' desire and need to work, and their value. Such a statement reassures employees that the employer supports them. The health status of someone with HIV may vary from healthy to critically ill. At work, the ultimate concern is whether the employee can satisfy job expectations. For example, "Procedures may be adapted to provide reasonable accommodation so that people with disabilities may remain employed and productive for as long as possible. All employees, however, are expected to perform their job's essential functions with or without reasonable accommodation."
- **Performance Standards.** The ADA provides protections for people who are disabled and are "qualified" to perform their jobs. Although an employer may be expected to provide reasonable accommodation to a disabled employee or applicant, employers may terminate employees and refuse to hire individuals who cannot perform the job's essential functions with or without reasonable accommodation. For example, "While the ADA does protect disabled employees from employment discrimination, all employees, those with and without disabilities, have the same performance and conduct standards regarding hiring, promotion, transfer, and dismissal."
- **Reasonable Accommodation.** The ADA requires employers to provide reasonable accommodations for employees with disabilities. Employers do not have an obligation to provide any accommodation that imposes an undue hardship on the employer. Specific questions about the issue of reasonable accommodation and undue hardship should be directed to staff responsible for coordinating the requirements of the ADA. Such a policy statement might read, "The following options may be considered for people with HIV/AIDS: possible assignment or reassignment of job duties, working at home, leaves of absence, and flexible work schedules."
- **Confidentiality and Privacy.** Organizations that receive funds from a state agency for residential or direct client services or programs shall develop and use confidentiality guidelines to protect their clients' HIV/AIDS related medical information (HSC §85.115, "Confidentiality Guidelines"). Organizations that fail to adopt and use confidentiality guidelines are ineligible to receive state funds. Employees are not required to reveal their HIV status to employers. All medical information that an HIV infected employee provides to medical or management personnel is confidential and private. Employers may not reveal this information without the employee's knowledge and written consent, except as provided by law (HSC §81.103, "Confidentiality; Criminal Penalty"). A suggested policy statement might be, "This agency will protect the confidentiality of employee medical records and information. Written consent of the employee must be obtained to share any confidential information with other staff. Those with access to confidential information must maintain strict confidentiality and privacy, separating this information from employees' personnel records. Individuals who fail to protect these employee rights commit a serious offense, which may be cause for litigation resulting in both civil and criminal penalties, and may result in dismissal."
- **Coworker Concerns.** Employers need to be aware of the concerns that coworkers may have about an HIV-infected coworker. A policy statement that acknowledges employee concerns and offers HIV/AIDS education helps to increase awareness and decrease fear. Equally

important is a policy statement that clarifies the limits of an employer's response to coworker concerns, e.g., "Employees do not have the right to refuse to work with someone who has any disability."

- **Employee Education.** Any health care facility **licensed** by TDH, the Texas Department of Mental Health and Mental Retardation, or the Texas Department of Human Services must require its employees to complete an educational course about HIV infection (HSC §85.010). For example: "All employees will receive education about methods of transmission and prevention of HIV infection and related conditions." In response to HSC §85.004, "Educational Programs," TDH developed model education program guidelines, which are available from TDH, HIV/STD Health Resources Division, 1100 W. 49th Street, Austin TX 78756, 512-490-2525. Employers may also find the CDC's educational kit, Business Responds to AIDS, useful in developing educational courses. The kit is available at the address listed in the section, "Where to Go for Help" below. HIV/AIDS education should address employee concerns about HIV communicability to themselves, their families, and coworkers. Experience shows that educated coworkers usually respond to people with HIV/AIDS with support, rather than with fear and ostracism due to misconceptions. Education programs must stress that agency employees who provide direct client services may face occupational exposure to a client's blood, semen, vaginal secretions, or other body fluids that are considered high-risk for transmission of blood born pathogens, including HIV/AIDS. All individuals receiving direct services are clients and include individuals who are physically or mentally impaired and those confined to correctional or residential facilities. All state agencies should have, as part of their employee education program, comprehensive policies and protocols based on universal precautions, body substance isolation, and barrier methods. These precautions prevent the spread of infection in clinical settings. The employer's careful planning reflects a commitment to the work force and community's health and well-being.
- **Assistance**. Some employers have designated benefits programs available to employees and family members with HIV infection. Such programs may:
  - Make referrals for testing, counseling, medical, and psychosocial services
  - Provide HIV/AIDS workplace training for managerial staff
  - Liaise between managers and the employer's clinical and occupational health programs
  - Provide counseling for employees who irrationally fear coworkers or clients

Employers without an employee assistance program may consider working with other organizations, which include local health departments, AIDS services organizations, American Red Cross chapters, community support groups, clinical treatment and counseling services, and the religious community.

Example: An employee who wants assistance concerning a disability or a life-threatening illness should contact the Personnel Office. This agency offers the following resources to help employees and managers deal with these issues: education and information concerning HIV/AIDS; confidential referral to supportive services for employees and dependents affected by life-threatening illnesses; and benefits consultation to help employees effectively manage health, leave, and other benefits."

5.1.6 Where to Go for Help

Refer employees to the Texas HIV/STD InfoLine, 800-299-AIDS, or other appropriate resource. This toll-free HIV/AIDS and STD information and referral service is sponsored by TDH. It provides referrals to HIV/AIDS testing sites; prevention, case management and treatment providers; STD clinics; and other related service organizations. Information and referral is available for English- and Spanish-speaking callers, and for those who are hearing impaired.

For additional guidance, consult the CDC's *Business Responds to AIDS Manager's Kit*. This kit includes a large section on workplace policies with information on the ADA, small businesses, health insurance, Social Security Disability Insurance, and Supplemental Security Income (CDC National AIDS Clearinghouse BRTA Resource Service, PO Box 6003, Rockville MD 20849-6003, 800-458-5231). The CDC National AIDS Hotline is a 24-hour toll-free service

providing referrals and free educational materials to the public regarding AIDS transmission, prevention, risk reduction, testing, symptoms, and other related issues. Call 800-342-AIDS for information in English, 800-344-7432 in Spanish, and 800-243-7889 for hearing impaired.

5.1.7 State Agencies Listed Under HSC §85.113

The HSC §85.113, "Workplace Guidelines for State Contractors" states "An entity that contracts with or is funded by any of the following state agencies to operate a program involving direct client contact shall adopt and implement workplace guidelines similar to the guidelines adopted by the agency that funds or contracts with the entity." These agencies include the following: Texas Commission on Alcohol and Drug Abuse, Texas Commission for the Blind (TCB), Texas Commission for the Deaf and Hearing Impaired, Texas Department of Criminal Justice, TDH, Texas Department of Human Services, Texas Department of Mental Health and Mental Retardation, Texas Juvenile Probation Commission, Texas Rehabilitation Commission, and Texas Youth Commission.

5.2 THSteps Medical Checkups Periodicity Schedule Referral

Refer to: "THSteps Medical Checkups Periodicity Schedule for Infants and Children" on page 11 and "THSteps Medical Checkups Periodicity Schedule for Adolescents" on page 12.

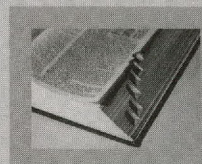
Appendix

A

Glossary

A	B	C	D	E	F	H	I	L	M	N	O	P
Q	R	S	T	U	V	W	Y					

A	
AAP	American Academy of Pediatrics
AIS	Automated Inquiry System
B	
BMI	Body Mass Index
C	
CBO	Community-Based Organization
CCP	Comprehensive Care Program
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHC	Comprehensive Health Centers
CLIA	Clinical Laboratory Improvement Amendments
CLPPP	Childhood Lead Poisoning Prevention Program
CM	Case Management
CMS	Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration, HCFA)
Compass21	Computerized Medicaid Claims Processing Assessment System
COPC	Community-Oriented Primary Care
CPS	Child Protective Services, Texas Department of Protective and Regulatory Services
CPW	Case Management for Children and Pregnant Women
CSHCN	Children with Special Health Care Needs Program (formerly CIDC)
D	
DHHS	(US) Department of Health and Human Services (cf. HHS)
DISPRO	Disproportionate Share Hospital
DME	Durable Medical Equipment
DOB	Date of Birth



D	
DOS	Date of Service
DPRS	(Texas) Department of Protective and Regulatory Services
E	
ECF	Extended Care Facility
ECI	Early Childhood Intervention
EOB	Explanation of Benefits
EOM	End of the Month
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
F	
FFP	Federal Financial Participation
FFY	Federal Fiscal Year (October 1–September 30)
FPIL	Federal Poverty Income Limit
FQHC	Federally Qualified Health Center
FSY	Fee Screen Year
FY	Fiscal Year
H	
HAASC	Hospital-Affiliated Ambulatory Surgical Center
HASC	Hospital Ambulatory Surgical Center
HB	House Bill
HBP	Hospital-Based Physician
HCPCS	Healthcare Common Procedure Coding System
HCBS	Home- and Community-Based Services
HCFA	Health Care Financing Administration (now known as Centers for Medicare and Medicaid Services, CMS)
HEENT	Head, eyes, ears, nose, and throat
HHA	Home Health Aide Home Health Agency
HHS	(US Department of) Health and Human Services
HHSC	(Texas) Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
I	
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modifications
ICF	Intermediate Care Facility
ID	Identification
IEP	Individual Education Plan
IHC	Indigent Health Care (Unit)
IHFSP	In-Home and Family Support Program

L	
LAR	Legislative Appropriation Request
LBB	Legislative Budget Board
LMFT	Licensed Marriage and Family Therapist
LMSW-ACP	Licensed Master Social Worker-Advanced Clinical Practitioner
LTC	Long Term Care
M	
MAO	Medical Assistance Only
MCAC	Medical Care Advisory Committee
MCAIS	Managed Care Automated Inquiry System
MCO	Managed Care Organization
MCP	Monthly Capitation Payment
MDCP	Medically Dependent Children's Program
Medicaid	Texas Medical Assistance Program, Title XIX, Social Security Act, as amended
MFADS	Medicaid Fraud and Abuse Detection System
MFCU	Medicaid Fraud Control Unit
MH	Mental Health
MHMR	Mental Health and Mental Retardation
MHR	Mental Health Rehabilitation
MIHIA	Maternal and Infant Health Improvement Act
MMIS	Medicaid Management Information System
MNIL	Medically Needy Income Limit
MNP	Medically Needy Program
MPI	Medicaid Program Integrity
MQC II	Medicaid Quality Control II
MQMB	Medicaid Qualified Medicare Beneficiary
MR	Mental Retardation
MTP	Medical Transportation Program
N	
NBS	Newborn Screening (Neonatal Screening)
NPI	National Provider Identifier
O	
OAG	Office of Attorney General
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
P	
PA	Physician Assistant Physician's Authorization Prior Authorization Public Assistance
PACT	Program for Amplification for Children of Texas (hearing aids/services)
PAN	Prior Authorization Number

A

P	
PCCM	Primary Care Case Management
PCN	Program Case Number
PCP	Primary Care Physician
PE	Presumptive Eligibility
PHC	Primary Home Care
PHP	Prepaid Health Plans
PHR	Public Health Region [number]
PHS	Purchased Health Services
PMPM	Per Member Per Month [Capitation (or Premium) payments]
POC	Plan of Care
POS	Place of Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
Q	
QA	Quality Assurance
QA/UR	Quality Assurance/Utilization Review
QMB	Qualified Medicare Beneficiary
R	
R&S	*Remittance and Status* Report
S	
SAVERR	System for Application, Verification, Eligibility, Reports, and Referrals
SB	Senate Bill
SFY	State Fiscal Year (September 1 – August 31)
SHARS	School Health and Related Services
SNF	Skilled Nursing Facility (see also ICF and ECI)
SNV	Skilled Nursing Visit (also known as, SNC, RN visit, or LVN Visit)
SOC	Start of Care (concerning Home Health claims)
SSA	Social Security Administration
SSI	Supplemental Security Income (Program)
STAR	State of Texas Access Reform (in LoneSTAR Health Initiative)
STAT File	Statistical File
T	
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TCADA	Texas Commission on Alcohol and Drug Abuse
TCB	Texas Commission for the Blind and Visually Handicapped
TDCI	Texas Drug Code Index
TDH	Texas Department of Health
TDHS	Texas Department of Human Services
TDPRS	Texas Department of Protective and Regulatory Services

T	
TDMHMR	Texas Department of Mental Health and Mental Retardation
TEA	Texas Education Agency
TEFRA	Tax Equity and Fiscal Responsibility Act (of 1982)
THHSC	Texas Health and Human Services Commission
THSteps	Texas Health Steps (Federal EPSDT Program)
THSteps-CCP	Texas Health Steps – Comprehensive Care Program
TMA	Texas Medical Association
TMHP	Texas Medicaid & Healthcare Partnership
TMMIS	Texas Medicaid Management Information System
TMQC	Texas Medicaid Quality Control
TNA	Texas Nurses Association
TOS	Type of Service
TPI	Texas Provider Identifier
TPSI	Texas Preschool Screening Inventory (for hearing: cf PDQ, DDST, and DDST-R)
TVFC	Texas Vaccines for Children Program
U	
USDHHS	US Department of Health and Human Services
V	
VFC	Vaccines for Children (Program)
VIN	Vendor Identification Number (tax ID number)
W	
WIC	Women, Infants, and Children (Program)
Y	
YTD	Year-to-Date

Appendix

B

Communication Directory

B.1 HHSC Public Health Regions Map 86

B.2 THSteps Regional Contacts 87

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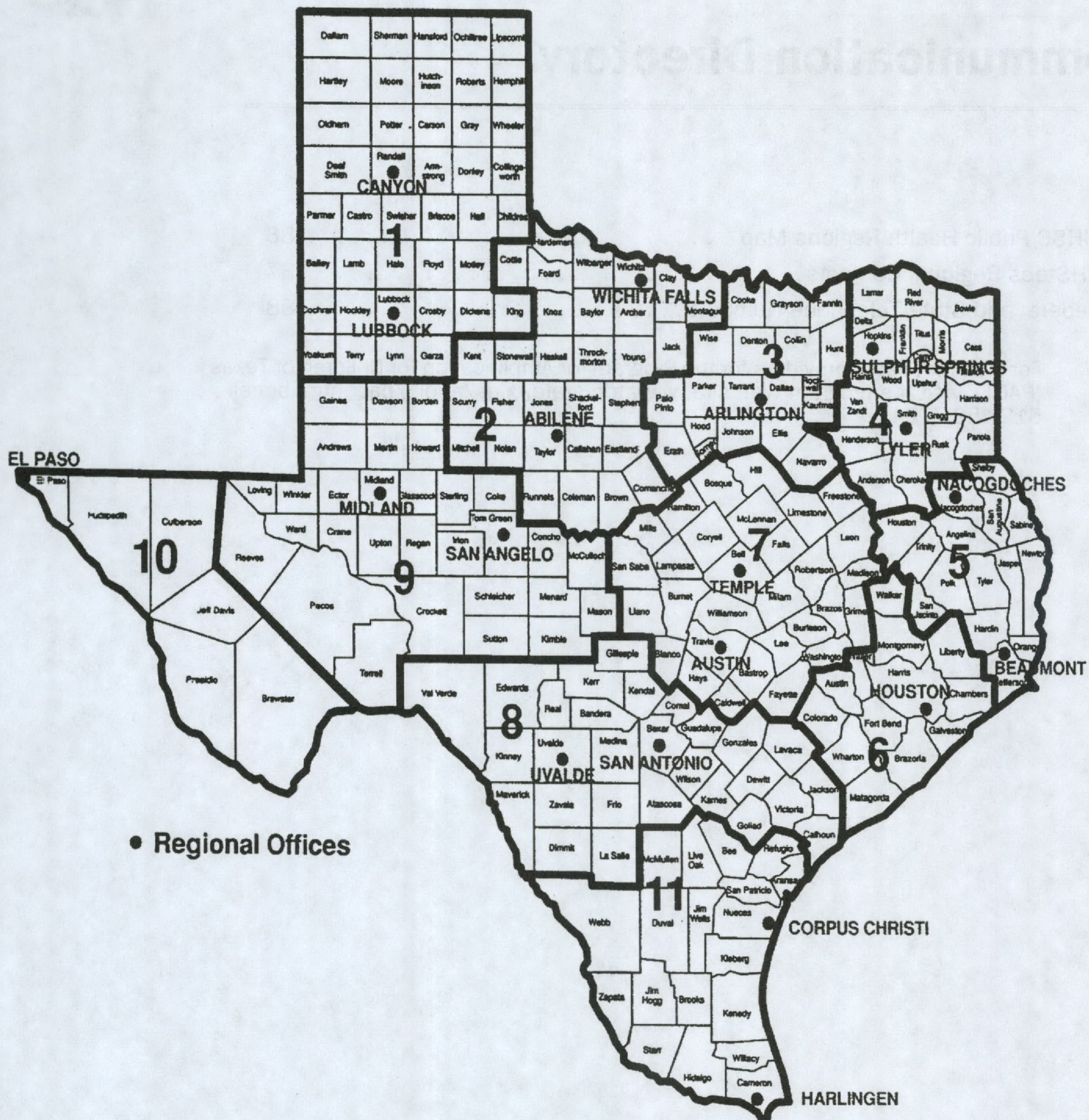
Note: For a current list of providers for the Program for Amplification for Children of Texas (PACT), visit the program Web site, www.tdh.state.tx.us/audio/pact.htm, or call 512-458-7724.

B.1 HHSC Public Health Regions Map



B.2 THSteps Regional Contacts

For provider relations and assistance with missed appointment by clients, contact the following:

Public Health Region	Contact	Address	Telephone Number
1	Beverly Ham THSteps Regional Manager	1109 Kemper Lubbock TX 79403	806-767-0350 fax: 806-767-0363
2/3	Barbara Columbus THSteps Regional Manager	1301 S Bowen Road, Suite 200 Arlington TX 76013	817-264-4900
4/5N	Vacant THSteps Manager	1517 West Front Tyler TX 75702	903-533-3256
6/5S	Judith Morris THSteps Manager	5425 Polk, Suite J Houston TX 77023	713-767-3101
7	Leslie Anderson THSteps Manager	2408 South 37th Street Temple TX 76504	254-778-6744
8	Starlite Folley THSteps Manager	7430 Louis Pasteur San Antonio TX 78229	210-949-2112
9/10	Marta Saldana THSteps Manager	401 E Franklin Street, Suite 200 El Paso TX 79901	915-834-7675
11	Russell Armstrong THSteps Manager	601 West Sesame Drive Harlingen TX 78550	956-444-3257

B

B.3 Federal and State Telephone Numbers

Department/Program	Telephone Number
Adolescent Preventive Visit Pap Smear Supplies/Forms Texas Center for Infectious Disease (Women's Health Laboratories, San Antonio TX)	210-534-8857 ext. 2357
AIDS Hotline, National	800-342-AIDS 800-342-2437
Case Management for Children and Pregnant Women (CPW)	512-458-7111
Child Abuse Intake (Texas Department of Protective and Regulatory Services)	800-252-5400
Children's Vision Program	512-458-7420
CLIA Hotline CLIA Provider Registration/Certification	410-290-5850
CLIA Regulations from US Government Printing Office	202-783-3238
Client Abuse Hotline for Nursing Facilities (TDHS)	800-458-9858
Client Inquiry Hotline (Medicaid questions from clients with Medicaid Only)	800-252-8263
Family Planning Program (TDH)	512-458-7796
Fraud or Abuse of Provider Services (THHSC Office of Investigations and Enforcement)	512-424-6519
Fraud or Abuse in Nursing Facilities (TDHS)	512-458-9858
HIV-STD InfoLine	800-299-2437
HIV Medication Program, Texas	800-255-1090
Immunization Division (TDH)	800-252-9152
Interpretation of Lab Results (TDH) Report of Lab Results (TDH)	512-458-7680 512-458-7578
Laboratory Supply Orders (TDH)	512-458-7661 fax: 512-458-7672
Managed Care (LoneSTAR Health Initiative or STAR Health Plan) (HHSC)	512-794-6862
Newborn Screening (TDH)	512-458-7700
Nutrition Services (TDH)	512-458-7111
Program for Amplification for Children of Texas (PACT - TDH)	512-458-7724
Texas Health Steps (Central Office)	512-458-7745
Snellen Letter ("Tumbling E" Wall Chart)	713-526-2559
Texas Pre-School Screening Inventory (TPSI) Worksheets and Manuals	512-458-7111 ext. 2867
Texas Vaccines for Children (TDH)	800-252-9152
Vendor Drug Program (Specifically for pharmacy use)	800-435-4165 or 512-338-6962

Appendix

C

Laboratory Procedures

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C.1 Overview

Providers are to follow the procedures and guidelines listed below when collecting samples for laboratory screening. Universal precautions should be observed.

Specimens submitted to TDH for blood lead tests, total hemoglobin tests, and hemoglobin type tests should consist of whole blood collected in collection tubes containing the anticoagulant ethylene diamine tetraacetic acid (EDTA) (one tube per patient). Specimens for rapid plasma reagin (RPR) Card Test must be clotted blood or serum collected in a red top collection tube.

C.2 Venipuncture

The venipuncture technique is strongly recommended over the capillary method. A capillary specimen is subject to false values due to dilution, hemolysis, or lead contamination. Mix specimens collected in vacuum tubes with anticoagulant vigorously to ensure proper mixing.

C.3 Capillary (Finger/Heel Punctures)

In response to questions about the use of capillary punctures to obtain blood specimens in children younger than age 1, the following quotation has been taken from the October 1991, Centers for Disease Control and Prevention (CDC) publication, "Preventing Lead Poisoning in Young Children," page 82, Item C:

> Puncturing of the fingers of infants less than age 1 is not recommended. Puncturing of the heel is more suitable for these children (NCCLS, 1986).

Except for an RPR, a capillary specimen is acceptable. If the child is younger than age 1 year, a heelstick may be performed. If capillary specimen collection is used, note the following information:

Note: Clotted blood or an insufficient quantity of blood are the two primary reasons specimens are unsatisfactory for TDH laboratory testing.

About 40 clotted specimens are detected in every 1,000 THSteps fingerstick specimens the laboratory receives. Unfortunately, these specimens cannot be accurately tested for lead or hemoglobin. If less than 500 uL, there may not be sufficient sample to perform these tests. In either situation, the laboratory sends a report explaining why a specimen was unsatisfactory for testing.

C.4 Causes of Unsatisfactory Specimens

The following are some causes of unsatisfactory specimens:

- Slow Blood Flow – Clotting can occur before blood comes in contact with anticoagulant. Placing a warm towel on the puncture site for 1–3 minutes can increase blood flow. For fingersticks, strike the fingertip slightly off center with a lancet and hold the finger at a level below the patient's heart so that gravity can assist in speeding specimen collection.
- Inadequate Mixing – Blood does not mix well in capillary blood collection devices. Shake vigorously. THSteps laboratory procedures are not adversely affected by shaking whole blood.
- Over-filled Vial – Fill vial **only** half full (500 uL). A vial filled more than half-full has a lower ratio of anticoagulant to blood, which may cause blood to clot. Heat during shipment can cause sample expansion, thereby dislodging the collection cap. Also, it is difficult to mix a full tube.
- Date of Expiration – Vials that are beyond their expiration date have less effective anticoagulant. Retain the expiration date provided with capillary blood collection devices and replace these as the date approaches.
- Contamination – Follow these guidelines to prevent contamination:
    - A soap and water wash of the patient's hands and feet and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination
    - When obtaining the specimen, assure noncontamination with collection techniques (i.e., wearing gloves).
    - Discard dropped collection vials.
    - Collect blood through the capillary top of the container or drop into the tube if it does not have such a top.
    - Do not use venipuncture tubes to collect capillary samples. (There is excessive anticoagulant in the venipuncture tubes for the smaller samples.) The result is a diluted specimen that is unsuitable for testing.

C.5 All THSteps Specimens

Specimens need to be:

- Placed into a mailing container ensuring that the capillary blood collector caps are tightly secured. All venipuncture tubes must be packed carefully to avoid breakage in shipment.
- Mailed on the day of collection if possible. Do not hold for mailing longer than three days. Refrigerate specimens that cannot be mailed immediately. Do not freeze. Do not stack.
- Placed in the dark immediately after collection for lead screening analysis, for example, in a closed mailer.

C.5.1 Submission

Specimens submitted to the TDH laboratory for routine testing must be accompanied by the appropriate G-1B request form that is supplied by TDH. Each form must contain all the requested information legibly displayed through all copies of the form.

Important: The space labeled "clinic code" is optional for providers to use for designating their suboffices. Any alphanumeric entries in this space appear on the patient's test results report.

Each specimen tube submitted must have the first and last name of the patient as it appears on the lab request form (including "Jr.," "III," and so forth). Printed labels with the patient's name may be used to label specimen and test request forms. Enter the code letter for suboffices using the same TPI in the "Clinic Code" space.

The TDH laboratory is licensed under Clinical Laboratory Improvement Amendments (CLIA) of 1988 and therefore must meet certain legal requirements. A recent licensure clarification requires that a patient's specimen must have the patient's name permanently attached to the specimen tube. The accompanying test request form must have the same name exactly as it appears on the tube.

This requirement means that, for a THSteps specimen, laboratory tests may only be performed if the specimen tube is labeled and the patient's name on the tube exactly matches the test request form. A suggestion for fingerstick collection tubes, i.e., capillectors: Write the patient's name on adhesive, small address label medical, or masking tape, or on the tube (indelible marker only) exactly as it appears on the test request form so the patient's name is attached to the tube.

C.5.2 Reports of Laboratory Testing

Laboratory reports are received by the provider approximately seven to 10 days after the specimens are mailed to TDH. Laboratory processing takes approximately three working days plus transit time to and from the TDH laboratory in Austin. You may inquire about reports not received after 14 days by writing or calling the TDH laboratory, 512-458-7578; collect calls are not accepted. (Call 512-458-7331 for information about newborn testing.)

Complete information, instruction (including blood sample collection procedures), and newborn screening forms are available from the following address:

Texas Department of Health
Bureau of Laboratories
1100 West 49th Street
Austin TX 78756-3199
512-458-7661 (no collect calls will be accepted)

Appendix

D

Lead Screening

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D.1 Lead Screening Procedures and Follow Up

Providers may obtain more information about the medical and environmental management of lead poisoned children from the TDH Childhood Lead Poisoning Prevention Program by calling 800-588-1248.

Blood specimens for lead screening are evaluated by direct measurement of lead concentration in the specimen. As of October 23, 1992, acceptable limits for lead concentration were lowered from <25 μg/dL to <10 μg/dL with a lead concentration of 10 μg/dL or higher now being reflected as above the acceptable limit. The provider should note the following for the lead screen analysis:

- The (capillary) lead screen analysis is subject to a false-positive result from skin lead contamination during collection. A soap and water wash of the patient's hands/feet and the collector's hands (or the wearing of gloves) must be performed to minimize the chance of contamination. Alcohol cleansing alone is not sufficient.
- The EP and the blood lead screening results should be compared to assess the relative risk of lead poisoning. An elevated EP result (≥35 μg/dL) indicates high correlation with physiological exposure to lead when compared to a blood lead concentration ≥25 μg/dL. A normal EP result (<35 μg/dL) for a blood lead concentration ≥25 μg/dL, however, is a strong indication of sample contamination.
- The EP analysis is not performed on blood lead elevations between 10 μg/dL and 24 μg/dL because the EP analysis cannot reliably indicate physiological status of lead exposure at the low abnormal concentration.

D.1.1 Client Lead Poisoning Prevention Counseling

As part of the anticipatory guidance given during a client's medical screening visit, all families must be given detailed lead poisoning prevention counseling and childhood lead prevention material. The following is an excerpt on anticipatory guidance from the Centers for Disease Control's October 1991 statement on "Preventing Lead Poisoning in Young Children."

> Anticipatory guidance means "teaching parents about major sources of lead and how to prevent poisoning" and "tailoring guidance to likely hazards in the community." Pediatric health care providers consider education to be an integral part of well-child care. Along with educating parents about nutrition and developmental stages, providers should discuss the potential hazards of lead. They should focus on the major preventable sources of high-dose lead poisoning – lead-based paint and take-home exposures from parents' occupations and hobbies. Parents should be told of the potential dangers of peeling lead-based paint, potential hazards of removing peeling lead-based paint, potential hazards of renovating older homes, and need for good work practices if their occupations or hobbies expose them to lead. Other education should be tailored to potential exposures in the community. Where water lead levels are a concern, parents should be advised to use only fully flushed water (that is, water that has not been standing in pipes for a prolonged time) from the cold-water tap for drinking, cooking, or preparing infant formula.

D.1.2 Follow-Up Physician Care Guidelines

Note that providers are responsible for initiating environmental assessments for children with blood lead levels of greater than or equal to 15 µg/dL. Providers are responsible for confirming capillary blood lead results with a venous blood lead measurement on children with blood lead levels of 15 µg/dL or above.

If the initial lead screen is elevated, recalling children to take a venous blood sample can be billed as a follow-up medical checkup visit, using Section 10 on the lab form. The specimen can be submitted to the TDH Clinical Chemistry Laboratory the same way as for all other THSteps laboratory blood specimens.

Refer to: "Follow-Up Care Guidelines Summary Table" on page 27 and "Guidelines for Follow Up of Elevated Blood Leads" on page 95 for interpretation of laboratory test results and guidelines for follow up for children with elevated blood lead levels.

D.1.3 Guidelines for Follow Up of Elevated Blood Leads

This table presents interpretation of blood lead test results and follow-up activities. Advised protocols for follow up of elevated blood lead in children younger than age 6.

This table presents interpretation of blood lead test results and follow-up activities.
Advised Protocols for follow up of elevated blood lead in children younger than age 6.
Blood lead ≤ 9 µg/dL (Class I): A child in Class I is not considered lead poisoned.
Blood lead 10-14 µg/dL (Class IIA): a. The parents should be informed (face to face, by telephone, or by letter) that they should make an appointment for the child in 3 to 4 months. b. Test every 3 to 4 months until two consecutive tests are < 10 µg/dL or three consecutive tests are < 15 µg/dL.
Blood lead 15-19 µg/dL (Class IIB): a. Confirm capillary results with venous blood specimen. Skin contaminants can cause falsely elevated results. The interassay variability of the blood lead assay is + or -3 µg/dL. Repeat venous testing should be done within a month if possible as levels can rise acutely. b. As (b) above. Tracking should be employed to ensure follow up. c. Supply parent with information concerning lead poisoning prevention, proper nutrition (adequate iron, calcium, zinc, and protein), appropriate hygiene practices (thorough damp mopping and wet wiping, frequent hand washing, and so on), and controlling pica. d. Conduct an environmental assessment INTERVIEW (TDH form #M-100). Obtain this form from HHSC, Literature and Forms Division, 1100 West 49th Street, Austin TX 78756-3199, or from the TDH Web site, www.tdh.state.tx.us/lead/leadhome.htm. This step is the first in identifying the source of lead. e. If two consecutive follow-up tests 3 to 4 months apart remain in this range, the parents have been thoroughly counseled and the INTERVIEW has been completed, a HOME VISIT may be indicated to assess the environment for lead contaminants. The local or regional health department may assist you in home investigations. First contact your local health department. If a representative is unable to conduct the home visit or no health department exists in your town, contact the regional HHSC office. If staff is unavailable for a home visit, the regional health department may refer a request directly for environmental investigation. f. An ENVIRONMENTAL INVESTIGATION is needed only when the INTERVIEW and HOME VISIT have failed to identify the source of lead. This investigation can be requested from the local or regional health department. If the child spends most of his or her time with a baby sitter, at a day care center, school, or other home, this location must be investigated also. (Detection and Management of Childhood Lead Poisoning, TDH, Winter 1996)
Blood lead 20-44 µg/dL (Class III): g. Steps (a) through (f) above. The repeat test (venous sample) should be done within one week. If confirmed to be ≥ 20 µg/dL: h. Conduct (or refer for) a complete medical evaluation: physical exam, including, but not limited to, growth assessment, blood pressure, hearing acuity, peripheral nerve function; developmental assessment; and laboratory assessment. Check for iron deficiency as it often co-exists with lead poisoning and can exacerbate lead toxicity. Serum iron, iron-binding capacity, and ferritin should be measured. Serum ferritin ≤ 12 µg/dL indicates iron deficiency. A blood lead ≥ 40 µg/dL should prompt a serum creatinine to assess renal function. i. Some physicians advise oral medications if blood lead remains in this range. Call the HHSC Childhood Lead Poisoning Prevention Program at 512-458-7111, ext. 6441, for the name of a physician or institution willing to advise on treatment. It is inadvisable to treat medically without identifying and removing the source of contamination. j. Abatement or containment of lead source.
Blood lead 45-69 µg/dL (Class IV): (g) through (i) as above. Begin medical treatment and environmental assessment and remediation within 48 hours. Pharmacologic treatment is indicated and should be conducted under the guidance of a physician experienced in the treatment of lead poisoning.
Blood lead ≥ 70 µg/dL (Class V): Considered a medical emergency. Medical treatment and environmental assessment/remediation must begin immediately.

D.1.4 Environmental Investigations

One of the most critical aspects in the management of childhood lead poisoning is the determination of the source of a child's high blood lead level, so a family may take steps to protect the child from further exposure to lead. The Lead Assessment Interview Tool (M-100) is a TDH form designed for the provider to use to interview the parent or guardian of a child with a confirmed elevated blood lead level of 15 µg/dL or higher. If a likely source of exposure can be determined through this interview, parents are to be counseled and provided appropriate educational materials at the time of the interview.

If an exposure source is not apparent and the child's confirmed blood lead level is >20 µg/dL or remains between 15 and 19 µg/dL for 3 or more months, the provider should request assistance from the local health department or nearest TDH regional office. Staff from these offices are available to perform home visits and formal environmental investigations to identify sources of lead and assist in educating families in the prevention of lead poisoning. The completed, signed M-100 form can be used to request an environmental investigation of the child's residence, by sending it to the appropriate local or regional health department office.

D.1.5 TDH Assistance Regarding Lead Poisoning Prevention

Regional contacts and assessment tools are available to aid in the awareness and detection of childhood lead poisoning. Each TDH regional office has a designated regional lead poisoning prevention contact person. Providers may call this person to follow up if a child is lost.

Refer to: "Environmental Investigations" on page 96 for information on environmental investigations.

D.1.6 TDH Tracking of Elevated Blood Lead Screening

The Bureau of Children's Health Childhood Lead Poisoning Prevention Program (CLPPP) of TDH has established a follow-up program to track the care provided to children who have had a blood lead of 20 µg/dL or above detected during a THSteps medical checkup. If a screened child has a blood lead of ≥ 40 µg/dL, the provider will receive a telephone call from the laboratory and the CLPPP with an offer of technical assistance.

Physicians in various parts of the state have offered to be available to advise on treatment procedures for these children. This information will be offered when CLPPP staff calls the provider. For blood leads of > 20 µg/dL, a letter is sent requesting the provider to forward results of subsequent lead testing to the CLPPP. This letter is sent to the provider after CLPPP receives the laboratory results. A letter is also sent to the parent or guardian regarding the high lead level. The parent or guardian is encouraged to contact the health care provider to schedule another appointment. THSteps providers will continue to be contacted either by phone or mail by the Childhood Lead Poisoning Prevention Program (CLPPP) coordinator for follow up regarding children with blood levels of 20 µg/dL or greater.

D.1.7 Lead Poisoning Prevention Educational Material

Providers may order lead poisoning prevention brochures (in English or Spanish) in addition to the "Get the Lead Out – Detection and Management of Childhood Lead Poisoning: Guidelines for Physicians and Health Care Providers" by sending a fax on letterhead to the attention of the TDH warehouse manager. Be sure to include the catalog number, title of the brochure, quantity, your phone number, and the address and name of the person to which the materials should be sent. Also note that all newly enrolled THSteps providers will get the manual with the initial shipment of laboratory supplies.

The following table contains informational free lead poisoning materials available to order from the TDH Warehouse and CLPPP:

Free Lead Poisoning Materials Available to Order from TDH Warehouse and CLPPP	
Catalog No.	**Title**
1-301	Get the Lead Out: Intervention (English)
1-301A	Get the Lead Out: Intervention (Spanish)
1-302	Get the Lead Out: Prevention (English)
1-302A	Get the Lead Out: Prevention (Spanish)
1-303	Get the Lead Out: Renovation (English)
1-303A	Get the Lead Out: Renovation (Spanish)
1-306	Get the Lead Out: Detection and Management of Childhood Lead Poisoning; Guidelines for Physicians and Health Care Providers (Winter 1996)
13-32	Get the Lead Out with Good Nutrition (English/Spanish)
M-100	Lead Assessment Interview Tool
1-26	What Parents Need to Know About Lead Poisoning (English)
1-26A	What Parents Need to Know About Lead Poisoning (Spanish)
1-305	Which of These is Poisonous to Your Child (Poster) (English)
1-305A	Which of These is Poisonous to Your Child (Poster) (Spanish)
*	Get the Lead Out – Keep Your Child Safe from Lead (Poster)
1-304	My Child Doesn't Have Lead Poisoning (Poster)
*03-10164	Am I Poisoning My Food?
*03-10165	What Can I Do About the Lead Paint on My House?
*03-10166	The Doctor Said My Child Has Lead Poisoning – What Happens Next?
*03-10167	Is Your Job Poisoning Your Child?
*03-10168	Is Poison In Your Medicine?
*03-10078	What Does Lead Do To My Child's Body?
*03-10169	How Can I Clean Up Lead?
*03-10079	Do You Want To Keep Your Child Safe From Lead?
6-221	Child Lead Poisoning in Texas – Reporting by Health Care Providers and Labs
TDH Literature and Forms 1100 West 49th Street Austin TX 78756-3199	or fax request to 512-458-7707, ATTN: Warehouse Manager
Include the catalog number, title of item, amount needed (up to 300 of each), and address the material should be mailed. *** These items must be ordered directly from the Childhood Lead Poisoning Prevention Program at the above address or faxed to 512-458-7417.**	

D

Statutory Requirements

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Several specific legislative requirements affect the THSteps program and the provider's participation in the program. The legislation includes, but is not limited to, those included in this Appendix.

E.1 Communicable Disease Reporting

Diagnosis of sexually transmitted diseases (STDs), including HIV, are reportable conditions under Title 25 Texas Administrative Code (TAC), Chapter 97, Subchapter F. Providers must report confirmed diagnosis of STDs as required by 25 TAC §97.132–.234.

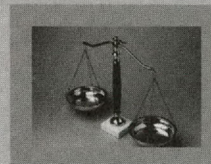
E.2 Early Childhood Intervention (ECI) Referrals

Early Childhood Intervention (ECI) is a coordinated system of services available in every Texas county for children from birth to age 3 with disabilities or delays. ECI is federally and state funded through the Individuals with Disabilities Education Act (IDEA, PL 105-17). ECI supports families to help their children reach their potential through developmental services.

Texas families who have children younger than age 3 with a disability or suspected delays in development must be referred to ECI. A medical diagnosis or a confirmed developmental delay is not needed for referral. A referral can be based on professional judgment or a family's concern.

All primary referral sources must refer a child younger than age 3 who may be in need of, and/or qualify for, comprehensive early intervention services. Referrals must be within two working days of identification and must be made to a contracted provider for evaluation and assessment of the child. Primary referral sources include:

- Hospitals, including prenatal and postnatal care facilities
- Physicians
- Parents



- Day care programs
- Local educational agencies
- Public health facilities
- Other social service agencies
- Other health care providers

Refer to: 34 Code of Federal Regulations (CFR) Section 303.321 and 25 TAC §621.45.

Early Childhood Intervention Web site, www.eci.state.tx.us for more information. For information and referral to services, call toll-free ECI Care Line at 800-250-2246 or the ECI state office at 512-424-6745.

E.3 Parental Accompaniment

Texas Human Resource Code §32.024(s) – (s-1) requires, as a condition for provider reimbursement, that a child younger than age 15 be accompanied by the child's parent, guardian, or other authorized adult at medical and dental visits or screenings under the state Medicaid program. The consent from the child's parent or guardian must have been received within the one-year period before the date the services are provided and must not have been revoked.

Providers will not be required to submit documentation to TMHP to verify compliance with this policy for TMHP to process claims. By submitting the claim for reimbursement, the provider acknowledges compliance with all Medicaid requirements. Additional assurances are not necessary.

Exception: School health clinics, Head Start programs, and child-care facilities are exempt from this policy if the clinic, program, or facility encourages parental involvement and obtains written consent for the services.

Refer to: Texas Human Resource Code §32.024(s) – (s-1); 25 TAC §33.134.

E.4 Newborn Blood Screening

Chapter 33, Subchapter B of the Health and Safety Code requires testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin, and congenital adrenal hyperplasia on all newborns. This testing is the responsibility of any provider attending the birth of a baby (for example, physicians, CNMs). All infants **must** be tested a second time at one to two weeks of age. If there is any doubt that a child younger than age 12 months was properly tested, the provider should submit the blood sample on the appropriate TDH Form NBS-3 to the TDH Newborn Screening Laboratory.

E.5 Abuse and Neglect

E.5.1 Requirements for Reporting Abuse or Neglect

Providers are required to comply with Texas Family Code Section 261.101, which states the following:

- A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report.
- If a professional has cause to believe that a child has been abused or neglected, or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, the professional shall make a report no later than the 48th hour after the hour the professional first suspects that the child has been, or may be abused or neglected, or is a victim of an offense under Section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes

teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

Additionally, Rider 18 of Article II of the General Appropriations Act, House Bill 1, 76th Legislative Regular Session, 1999, requires TDH to ensure that all Medicaid providers comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code relating to investigations of reports of child abuse and neglect and the provisions of TDH policy.

E.5.2 TDH Policy for Reporting Child Abuse and Neglect

Reimbursement will be made only to providers who have demonstrated a good faith effort to comply with child abuse reporting guidelines and requirements in Chapter 261 of the Texas Family Code and TDH policy. Provider staff will respond to disclosures or suspicions of abuse or neglect of minors by reporting to the appropriate agencies, as required by law.

All providers will adopt this policy as their own, report suspected sexual abuse of a child as described in this policy and as required by law, and develop internal policies and procedures that describe how it will determine, document, and report instances of abuse, sexual or nonsexual. This information is also available on the TDH and TMHP Web sites.

E.5.2.1 Procedures for Reporting Abuse or Neglect

Professionals as defined in the law, Texas Family Code, Section 261.101 (b), are required to report abuse or neglect no later than the 48th hour after the hour the professional first has cause to believe the child has been or may be abused or is the victim of the offense of indecency with a child.

Nonprofessionals shall immediately make a report after the nonprofessional has cause to believe that the child's physical or mental health or welfare has been adversely affected by abuse.

A report must be made regardless of whether the provider staff suspect that a report may have previously been made. Reports of abuse or indecency with a child should be made to one of the following:

- Texas Department of Protective and Regulatory Services (DPRS) if the alleged or suspected abuse involves a person responsible for the care, custody or welfare of the child (DPRS Texas Abuse Hotline at 800-252-5400 operated 24 hours a day, seven days a week)
- Any local or state law enforcement agency, the state agency that operates, licenses, certifies, or registers the facility in which the alleged abuse or neglect occurred
- The agency designated by the court to be responsible for the protection of children

The law requires that the report include the name and address of the minor, if known, name and address of the minor's parent or the person responsible for the care, custody or welfare of the child if not the parent, if known, and any other pertinent information concerning the alleged or suspected abuse, if known. Reports can be made anonymously.

A provider may not reveal whether the child has been tested or diagnosed with HIV or AIDS. If the minor's identity is unknown (e.g., the minor is at the provider's office to receive testing for HIV or an STD anonymously), no report is required.

E.5.2.2 Staff Training on Reporting Abuse and Neglect

All providers shall develop training for all staff on the policies and procedures in regard to reporting child abuse, including sexual abuse, and neglect. New staff shall receive this training as part of their initial training or orientation. Training shall be documented. As part of the training, staff shall be informed that the staff person who conducts the screening and has cause to suspect abuse has occurred is legally responsible for reporting. A joint report may be made with the supervisor.

Appendix

F

Hearing Screening Information

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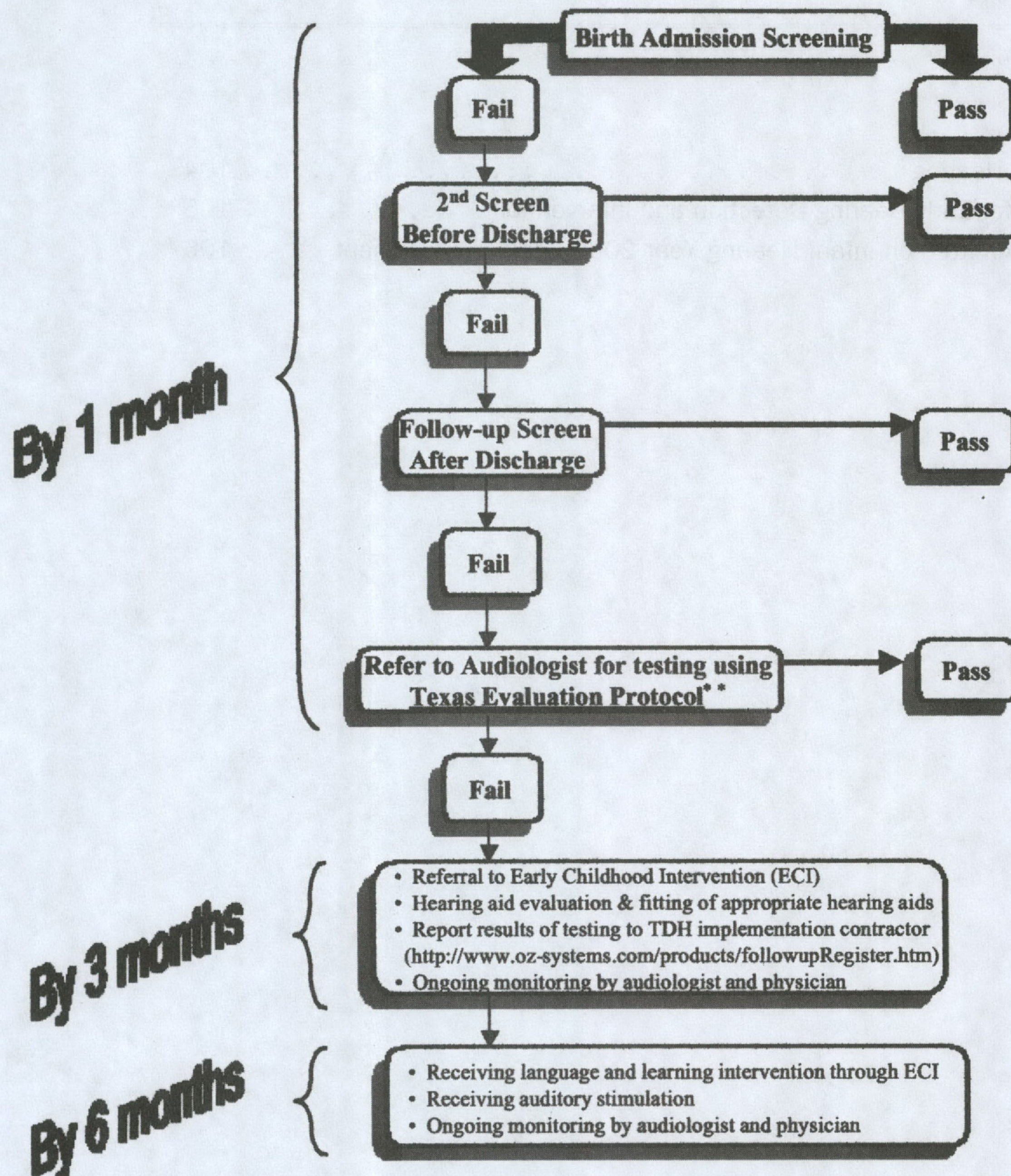
F.1 Newborn Hearing



* **Health and Safety Code, Chapter 47, §47.005 (c).** Information Concerning Screening Results and Follow-up Care: "Appropriate and necessary care for the infant who needs follow-up care should be directed and coordinated by the infant's physician or health care provider, with support from appropriate ancillary services."
American Academy of Pediatrics Position Statement (http://www.aap.org/policy/re9846.html)
Joint Committee on Infant Hearing 2000 Position Statement (http://www.aap.org/policy/jcihyr2000.pdf)
** **TDH Audiologic Evaluation Protocol** http://www.tdh.state.tx.us/audio/assumpt.htm

Texas Department of Health
Newborn Hearing Screening Program
www.tdh.state.tx.us/audio/audiology.htm
1-800-422-2956

F.2 Process for Early Hearing Detection and Intervention

1) Birth Screen: will be either screening Auditory Brainstem Response (ABR) or screening Otoacoustic Emissions (OAE)

Newborn's hearing **screened at birth facility**. If newborn does not pass, hearing rescreened performed before hospital discharge as well as the following:

- Newborn's family and physician given results of newborn hearing screen
- If newborn passes screen, physician will monitor hearing as part of periodic visits
- If newborn does not pass the rescreen, referral is made to a local resource for **follow-up screen**

2) Follow-up Screen: will be either screening ABR or OAE
   - Physician/medical home receives results
   - Screener/physician reports results to TDH contractor at www.oz-systems.com/products/followupRegister.htm
   - If newborn passes follow-up screen, physician will monitor hearing as part of periodic visits
   - If newborn fails the follow-up screen, referral is made to an audiologist for evaluation using Texas Pediatric Protocol for Evaluation (see flow chart)
   - For children whose families need financial assistance, application to TDH Program for Amplification for Children of Texas (PACT) is made
3) Evaluation using Texas Pediatric Protocol for Evaluation: will be diagnostic ABR and, if not previously done, OAE to verify cochlear involvement
   - Facilities use equipment norms for newborns, preferably ones that they have collected on their equipment
   - Protocols include air and bone conduction results using tone burst ABR, rather than click ABR, so that amplification may be appropriately fit
   - Physician/medial home receives results and makes referral to ECI
   - Physician/medical home monitors child (see flow chart)
   - Audiologist report results to TDH contractor as noted above and makes referral to ECI
   - Fitting of hearing aids by an audiologist when appropriate
   - Continue audiological assessment and/or monitoring as needed (usually monitor each 3 months for the first year of hearing aid use)
4) Referral to Early Childhood Intervention Program (ECI) by and Audiologist or Physician within two working days of identification of hearing loss
   - Referral for Deaf Education Services
   - Assessment and individual family service plan (IFSP) within 45 days of referral to ECI
   - ECI and Deaf Education Services are available to age 3 when determined by an IFSP
5) Deaf Education and/or other special education services available from ages 3 through 21 when determined by an Individual Education Plan (IEP)
6) Medical home/physician continues to monitor periodically. See the Joint Committee on Infant Hearing (JCIH) 2000 Position Statement for suggested monitoring protocols (see flow chart, "Newborn Hearing" on page 104).

F

F.3 Joint Committee on Infant Hearing Year 2000 Position Statement

The Joint Committee on Infant Hearing (JCIH) 2000 recommends the following indicators for use with neonates or infants (29 days through 2 years). These indicators place an infant at risk for progressive or delayed-onset sensorineural hearing loss and/or conductive hearing loss. Any infant with these risk indicators for progressive or delayed-onset hearing loss who has passed the birth screen should, nonetheless, receive audiologic monitoring every six months until age 3 years.

These indicators are:

- Parental or caregiver concern regarding hearing, speech, language, and developmental delay
- Family history of permanent childhood hearing loss*
- Stigmata or other findings associated with a syndrome known to include a sensorineural or conductive hearing loss or Eustachian tube dysfunction
- Postnatal infections associated with sensorineural hearing loss including bacterial meningitis*
- In-utero infections such as cytomegalovirus, herpes, rubella, syphilis, and toxoplasmosis
- Neonatal indicators specifically hyperbilirubinemia at a serum level requiring exchange transfusion, persistent pulmonary hypertension of the newborn associated with mechanical ventilation, and conditions requiring the use of extracorporeal membrane oxygenation (ECMO)*
- Syndromes associated with progressive hearing loss such as neurofibromatosis, osteopetrosis, and Usher's syndrome
- Neurodegenerative disorders, such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich's ataxia and Charcot-Marie-Tooth syndrome
- Head trauma
- Recurrent or persistent otitis media with effusion for at least three months*

Because some important indicators, such as family history of hearing loss, may not be determined during the course of universal newborn hearing screening programs, the presence of all late-onset risk indicators should be determined in the medical home during early well-baby visits. Those infants with significant late-onset risk factors should be carefully monitored for normal communication developmental milestones during routine medical care.

* See original document for citations

Joint Committee on Infant Hearing Year 2000 Position Statement
Principles and Guidelines for Early Hearing Detection and Intervention Programs, pages 23-24

Appendix

G

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G.1 Child Health Clinical Records

The use of ECH 1-7 and WIC 42, ECH 13, ECH 14, and ECH 15 forms is optional. These forms were developed to assist the provider in documenting all components of the medical check-up and can be downloaded from the THSteps Web site, www.tdh.state.tx.us/thsteps/forms.htm#child. Lead poisoning screening questionnaires can be downloaded from the Childhood Lead Poisoning Prevention Program Web site, www.tdh.state.tx.us/lead/default.htm. Tuberculosis screening questionnaires can be downloaded from the Tuberculosis Elimination Division Web site, www.tdh.state.tx.us/tb/forms/TBQuestionnaire-english.doc (form provided in English) and www.tdh.state.tx.us/tb/forms/TBQuestionnaire-spanish.doc (form provided in Spanish). If you are unable to access these forms from the Web sites, you may obtain a camera-ready copy by calling THSteps at 512-458-7745. Forms CH-9W through CH-12W may be ordered from the TDH Warehouse.

Stock Number	Form
ECH-1	Child Health History
ECH-2	Preventive Health Visit - Birth to 1 Month
ECH-3	Preventive Health Visit - 2–6 Months
ECH-4	Preventive Health Visit - 7–12 Months
ECH-5	Preventive Health Visit - 13 Months to 2 Years
ECH-6	Preventive Health Visit - 3–5 Years
ECH-7	Preventive Health Visit - 6–10 Years
CH-9W	Growth Chart - Infant Girl
CH-10W	Growth Chart - Infant Boy
CH-11W	Growth Chart - Child Girl
CH-12W	Growth Chart - Child Boy
WIC-42	24-Hour Dietary Recall and Assessment for Infants - Birth Through 11 Months
ECH-13	24-Hour Dietary Recall and Assessment for Children - 1 Through 4 Years
ECH-14	24-Hour Dietary Recall and Assessment for Children - 5 Through 9 Years
ECH-15	24-Hour Dietary Recall and Assessment for Teens - 10 Through 20 Years (Nonpregnant Teens)
	Texas Health Steps Primary Parent Questionnaire Risk Assessment for Lead Exposure
	Texas Health Steps Abbreviated Parent Questionnaire Risk Assessment for Lead Exposure
	TB Questionnaire

The Adolescent Health program recognizes the need to provide comprehensive services for teens and has developed a new series of health forms in an effort to assist health care providers in providing quality services. The new health forms with instructions will be available via the Texas Department of Health, Adolescent Health Program Web site, www.tdh.state.tx.us/adolescent/default.htm, or you may call 512-458-7745 for camera-ready copies.

Taking care of adolescent can be extremely rewarding. Providers can help shape a patient's relationship with the health care system and trust of health care providers. By helping guide adolescents toward taking responsibility for positive health behaviors, health care providers may impact the health and safety of a new generation of teens

G.2 Child Health History (2 Pages)

Child Health History

Texas Department of Health
Child Health Record
Preventive Health Visit

Client Information

Name: ____________________
DOB: ______ / ______ / ______ Age: ________ Sex: ________
SSN/Record No.: ____________________
Race/Ethnicity: ____________________
Informant/Relationship: ____________________

Pregnancy and Birth

G ___ P ___ AB ___
Total number of living children ______ Weight gain/loss ______
Mother's age at birth __________
Number of years between previous pregnancy and this child ______
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider ____________________
Vitamins: __ Y __ N Iron: __ Y __ N
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: __ Y __ N*
**If yes, proceed with "Child's Medical History.*

Maternal Complications

__ Vaginal bleeding
__ Anemia
__ Hypertension
__ Rh negative
__ Diabetes
__ Premature labor
__ Injury/hospitalization/surgery
__ Flu-like illness or high temp.
__ Kidney or bladder infection
__ STDs
__ Hepatitis (A, B, or C)
__ Exposure to TB
__ Exposure to lead/chemicals
__ Dental disease

Maternal Substance Use

__ OTC meds ____________________
__ Prescription meds ____________________
__ Tobacco ____________________
__ Alcohol ____________________
__ Street drugs ____________________
__ Caffeine ____________________

Family Medical History

Abbreviations for relatives listed below.

M - Mother	MGM - Maternal Grandmother	PGM - Paternal Grandmother
F - Father	MGF - Maternal Grandfather	PGF - Paternal Grandfather
S - Sibling	MA - Maternal Aunt	PA - Paternal Aunt
	MU - Maternal Uncle	PU - Paternal Uncle

___ Anemia//blood disorder
___ Heart disease before age 50
___ Cholesterol req. treatment
___ Hypertension/stroke
___ Asthma/allergy
___ Cancer
___ Diabetes
___ Epilepsy/seizures
___ Kidney problems
___ Muscle/bone disease
___ Genetic disease or major birth defects
___ Childhood hearing impairment
___ Tuberculosis

Y N HIV + individual in household (*do not identify*)
___ Other immunosuppression
___ Dental decay
___ Alcohol/drug abuse
___ Tobacco use
___ Learning disorder
___ Mental retardation
___ Psychiatric disorder
___ Physical/sexual/emotional abuse
___ Domestic violence
___ Other

Explanation of positive history:

Birth/Delivery

Place of birth ____________________
Birth attendant ____________________
Hours of labor ____________________

__ Term
__ Premature (Weeks)______
__ More than 2 weeks overdue

Type of delivery:
__ Vaginal
__ C-Section
__ Forceps

Complications:
__ Breech
__ Multiple birth
__ Other

Explanation/Other:

Nursery Course

Birth Weight ________ Birth Length ________ FOC ________

__ Difficulty with initial breathing
__ Heart murmur
__ Infection
__ Transfusion
__ Jaundice req. treatment
__ Seizures

Age at discharge: ________ ICN __________ days
Newborn blood screening (date/location):
1. ____________________
2. ____________________

Newborn hearing test (in hospital): ____ Normal _____Abnormal
Type of test: ____ABR ___ OAE ___ Unknown
Referral made: ___Y ___ N
Comments:

Child's Medical History

Immunizations current: __ Y __ N __ Record unavailable
Dental care/sealants current: __ Y __ N

__ Trauma/injuries
__ Hospitalizations
__ Surgery
__ Medications
__ Anemia
__ Early childhood caries
__ Hepatitis
__ Strep throat
__ Ear infections
__ Bladder/kidney infections
__ Pneumonia
__ Developmental delays
__ Vision problems
__ Hearing problems
__ Seizures
__ Environmental toxin exposure (lead, etc.)
__ Allergies
__ Asthma
__ Eczema
__ Substance use (alcohol, drug, tobacco)
__ Other

Explanation:

Date: __________ Signature/Title: ____________________ Signature/Title ____________________

Child Health History

If used for documentation: ____________________

Patient's Name: ____________________

Date: ____________________

Progress Notes

TDH-ECH-1

Rev. 8/02

G

G.3 Child Health Record (Birth–1 Month) (2 Pages)

Birth – 1 Month

Texas Department of Health
Child Health Record
Preventive Health Visit

Client Information

Name: ______________________
DOB: ______ / ______ / ______ Age: ________ Sex: ________
SSN/Record No.: ______________________
Race/Ethnicity: ______________________
Informant/Relationship: ______________________
Medical Home: ______________________

Family Profile and Health

____ No change in household since last visit

Child lives with:

____ Mother ____ Father ___ Stepparent ____ Grandparent
____ Other

Total adults living in home: ______________________
Total children living in home: ______________________
Primary caretaker for this child: ______________________
Relationship: ______________________

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ____ P ____ F

Type of Developmental Screen:

Standardized Parent Questionnaire: ______________________
Standardized Observational Screen: ______________________
Other: ______________________
Further assessment needed: ____ Y ____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems or parent concerns: ____ Y ____ N
Explain:
Major illness, injury, hospitalization, surgery (state when and describe):

Medications taken regularly – Type/Reason:

Physical Examination

Temp ________ Pulse ________ Resp ________
FOC ________ Height ________ Weight ________
(%) ________ (%) ________ (%) ________

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes (RR)	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine/hips
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat				**Neurologic:**
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breasts	__	__	__	Primitive reflexes

Additional documentation:

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* ____ Y ____ N

**If answered yes, further assessment needed.*

Breast-fed: Number of feedings in last 24 hours: ________
Length of feedings: ________ **WIC:** ____ Y ____ N
Formula-fed: Type: ______________________
Iron fortified: ____ Y ____ N
Ounces consumed in 24 hours: ______ Fluoride: ____ Y ____ N
Solid foods introduced at age:

Sensory

Vision Screen: ____ Normal ____ Abnormal
Hearing Screen: ____ Normal ____ Abnormal
Screen used: ____ TDH Hearing Checklist

Health Education

Injury Prevention

__ Car safety restraints
__ Crib safety
__ Burns
__ Falls
__ Drowning/bath safety
__ 911
__ Sleep position (SIDS)
__ Passive smoking

Behavior

__ Crying/colic
__ Sleeping
__ Infant temperature

Health Promotion

__ Care of skin, umbilical cord, circumcision
__ Family planning
__ Well-child care
__ When to call doctor

Nutrition

__ Breastfeeding
__ No solids until 4 months
__ Formula preparation
__ Infant held for bottle
__ No bottle in bed

Assessment

Plan

WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Newborn Screening: ____ Up to date ____ To be done today
Next appointment:

Date: ____________ Signature/Title: ______________________ Signature/Title ______________________

Birth – 1 Month

If used for documentation: ______________________

Patient's Name: ______________________

Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections, jaundice, cyanosis

Ears: Hearing or ear problems

Eyes: Eye discharge, excessive tearing

Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory:	History of murmur, trouble with breathing, wheezing
Gastrointestinal:	Bowel movement frequency, problems/concerns, vomiting
Genitourinary:	(Male) Normal stream, circumcision, number of wet diapers
Neuromuscular:	Seizures, sucking reflex, swallowing
Musculoskeletal:	Range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings:	Anxious, cries excessively or too little, irritable
Behavior:	Overactivity, listlessness
Social Interaction:	Failure to respond socially
Thinking:	Unattentive
Physical Problems:	Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other:	Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

- Can focus on object 8–15 inches in front of infant
- Startles to loud noise
- Equal movement of limbs
- Moves head from side to side while lying on stomach

Progress Notes

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2 – 6 Months

Texas Department of Health
Child Health Record
Preventive Health Visit

Family Profile and Health

____ No change in household since last visit

Child lives with:

____ Mother ____ Father ____ Stepparent ____ Grandparent ____ Other

Total adults living in home: ____________

Total children living in home: ____________

Primary caretaker for this child: ____________

Relationship: ____________

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ____ P ____ F

Type of Developmental Screen:

Standardized Parent Questionnaire: ____________

Standardized Observational Screen: ____________

Other: ____________

Further assessment needed: ____ Y ____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems or parent concerns: ____ Y ____ N

Explain:

Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Physical Examination

Hct/Hgb ______ Lead ______

Temp ______ Pulse ______ Resp ______

FOC ______ Height ______ Weight ______

(%) ______ (%) ______ (%) ______

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes (RR)	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine/hips
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat				**Neurologic:**
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breasts	__	__	__	Primitive reflexes

Additional documentation:

Client Information

Name: ____________

DOB: ____ / ____ / ____ Age: ______ Sex: ______

SSN/Record No.: ____________

Race/Ethnicity: ____________

Informant/Relationship: ____________

Medical Home: ____________

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* ____ Y ____ N

**If answered yes, further assessment needed.*

Breast-fed: Number of feedings in last 24 hours: ______

Length of feedings: ______ **WIC:** ____ Y ____ N

Formula-fed: Type: ______

Iron fortified: ____ Y ____ N

Ounces consumed in 24 hours: ______ Fluoride: ____ Y ____ N

Solid foods introduced at age:

Sensory

Vision Screen: ____ Normal ____ Abnormal

Hearing Screen: ____ Normal ____ Abnormal

Screen used: ____ TDH Hearing Checklist

Health Education

Injury Prevention

__ Car safety restraints
__ Falls, Infant walker
__ Burns
__ Choking management
__ Sleep position (SIDS)
__ Passive smoking
__ Pool/bath safety

Behavior

__ Parent/infant interaction
__ Sleeping
__ Inappropriate expectations
__ Daycare/babysitters

Health Promotion

__ Immunizations
__ Thermometer use, Tylenol
__ Teething, wipe teeth
__ When to call doctor
__ Well-child care
__ Family planning

Nutrition

__ Breastfeeding
__ No solids until 4 months
__ Formula preparation
__ Infant held (no bottle in bed)

Assessment

Plan

WIC: __ Referred __ Refused __ N/A

Immunizations: __ Up to date __ To be given today __ Deferred

Explain:

Lab:

Newborn Screening: ____ Up to date ____ To be done today

Next appointment:

Date: ______ Signature/Title: ______ Signature/Title ______

2 – 6 Months

If used for documentation: ______________________

Patient's Name: ______________________

Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, deviation, excessive tearing

Nose/Mouth/Throat: Nasal congestion

Cardio/respiratory:	History of murmur, trouble with breathing, wheezing
Gastrointestinal:	Bowel movement frequency, problems/concerns, vomiting
Genitourinary:	(Male) Normal stream, number of wet diapers
Neuromuscular:	Seizures, coordinated movements
Musculoskeletal:	Fractures, range of motion

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings:	Anxious, cries excessively or too little, irritable
Behavior:	Overactivity, listlessness
Social Interaction:	Failure to respond socially
Thinking:	Unattentive
Physical Problems:	Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other:	Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

2 Months	4 Months	6 Months
Smiles responsively	Looks for source of sound	Reaches for objects
Inspects surroundings	Hands together	Responds to own name
Vocalizes in play	Vocalizes to show displeasure	Vocal imitation, imitates speech sounds
Lifts head	Head steady in supported position	Rolls over

Progress Notes

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G.5 Child Health Record (7–12 Months) (2 Pages)

7 – 12 Months

Texas Department of Health
Child Health Record
Preventive Health Visit

Client Information

Name: ____
DOB: ____ / ____ / ____ Age: ____ Sex: ____
SSN/Record No.: ____
Race/Ethnicity: ____
Informant/Relationship: ____
Medical Home: ____

Family Profile and Health

____ No change in household since last visit

Child lives with:

____ Mother ____ Father ___ Stepparent ____ Grandparent
____ Other

Total adults living in home: ____
Total children living in home: ____
Primary caretaker for this child: ____
Relationship: ____

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ____ P ____ F

Type of Developmental Screen:

Standardized Parent Questionnaire: ____
Standardized Observational Screen: ____
Other: ____

Further assessment needed: ____ Y ____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:

Does the system review note any problems or parent concerns: ____ Y ____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Physical Examination

Temp ____ Pulse ____ Resp ____
FOC ____ Height ____ Weight ____
(%) ____ (%) ____ (%) ____

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine/hips
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat				**Neurologic:**
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breasts				

Additional documentation:

Nutrition

Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems* ____ Y ____ N

**If answered yes, further assessment needed.*

Breast-fed: Number of feedings in last 24 hours: ____
Length of feedings: ____ **WIC:** ____ Y ____ N
Formula-fed: Type: ____
Iron fortified: ____ Y ____ N
Ounces consumed in 24 hours: ____ Fluoride: ____ Y ____ N

Solid foods introduced at age:

Sensory

Vision Screen: ____ Normal ____ Abnormal
Hearing Screen: ____ Normal ____ Abnormal
Screen used: ____ TDH Hearing Checklist

Health Education

Injury Prevention

- __ Car safety restraints
- __ Falls (stairs, gates)
- __ Choking management
- __ Water safety/temp
- __ Poisoning
- __ Child proofing
- __ Passive smoking

Behavior

- __ Parent/infant interaction, expectations
- __ Speech development
- __ Sleep
- __ Separation protest
- __ Daycare

Health Promotion

- __ Immunizations
- __ Teething
- __ Cleaning teeth
- __ When to call doctor
- __ Well-child care
- __ Dental appointment
- __ Family planning

Nutrition

- __ Breastfeeding support
- __ Introduction of solids
- __ No bottle in bed
- __ Off bottle by 1 year

Assessment

Plan

TB: __ Y __ N **Dental referral made:** __ Y __ N
WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Newborn Screening: ____ Up to date ____ To be done today
Hct/Hgb ____ Lead ____
Hep C (if 12 months old or older and born to HCV infected woman) ____

Next appointment:

Date: ____ Signature/Title: ____ Signature/Title ____

7 – 12 Months

If used for documentation: ______________________

Patient's Name: ______________________

Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, deviation, wandering eye movement

Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing

Gastrointestinal: Bowel movement frequency, problems/concerns, vomiting

Genitourinary: (Male) Normal stream

Neuromuscular: Coordination

Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Anxious, cries excessively or too little, irritable

Behavior: Overactivity, listlessness

Social Interaction: Failure to respond socially

Thinking: Unattentive

Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems

Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

9 Months

Feeds self
Puts object in container
Babbles with inflection
Stands, holding on

12 Months

Begins to use objects correctly, such as drinking from a cup
Bangs two objects together
Uses one or two verbal labels for objects or people
Stands alone 2 seconds

Progress Notes

13 Months – 2 Years

Texas Department of Health
Child Health Record
Preventive Health Visit

Client Information

Name: ______
DOB: ____ / ____ / ____ Age: ____ Sex: ____
SSN/Record No.: ______
Race/Ethnicity: ______
Informant/Relationship: ______
Medical Home: ______

Family Profile and Health

____ No change in household since last visit

Child lives with:
____ Mother ____ Father ___ Stepparent ____ Grandparent
____ Other

Total adults living in home: ______
Total children living in home: ______
Primary caretaker for this child: ______
Relationship: ______

Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ____ P ____ F

Type of Developmental Screen:
Standardized Parent Questionnaire: ______
Standardized Observational Screen: ______
Other: ______

Further assessment needed: ____ Y ____ N

Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: ____ Y ____ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Dental Care:

Physical Examination

Temp ______ Pulse ______ Resp ______
FOC ______ Height ______ Weight ______
(%) ______ (%) ______ (%) ______

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine/hips
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat				**Neurologic:**
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breasts				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental* ____ Y ____ N

**If answered yes, further assessment needed.*

Usual Servings Per Day:
__ Dairy __ Formula __ Breast __ Vegetables WIC: __ Y __ N
__ Breads, cereal, rice, and pasta
__ Meat, poultry, fish, eggs, and dry beans
__ Fruits

Sensory

Vision Screen: ____ Normal ____ Abnormal
Hearing Screen: ____ Normal ____ Abnormal
Screen used: ____ TDH Hearing Checklist

Health Education

Injury Prevention
__ Car safety restraints
__ Choking, unsafe toys
__ Poisoning
__ Burns
__ Water safety/temp
__ Supervised play
__ Electrical injury
__ Passive smoking

Behavior
__ Parent/infant interaction
__ Social interaction
__ Limit TV
__ Set limits

__ Sibling rivalry
__ Toilet training

Health Promotion
__ Immunizations
__ Smoking in home
__ Well-child care
__ Dental care, appointment
__ Family planning
__ Daycare

Nutrition
__ Healthy diet/snacks
__ Iron-rich foods
__ Physical activity
__ Weaning
__ Off bottle by age 1

Assessment

Plan

Dental referral made: __ Y __ N
WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead ______
Hep C (if 12 months old or older and born to HCV infected woman) ______
Next appointment:

Date: ______ Signature/Title: ______ Signature/Title ______

13 Months – 2 Years

If used for documentation: ____________________
Patient's Name: ____________________
Date: ____________________

Key Elements

Systems Review

Skin: Rashes, infections
Ears: Hearing or ear problems
Eyes: Eye discharge, deviation, wandering eye movement
Nose/Mouth/Throat/Teeth: Nasal congestion

Cardio/respiratory: History of murmur, trouble with breathing, wheezing
Gastrointestinal: Bowel movement frequency
Genitourinary: Urinary frequency, (male) normal stream, dysuria, discharge
Neuromuscular: Seizures, coordination, gait
Musculoskeletal: Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings: Angry, sad, fearful, sullen, anxious, cries excessively or too little
Behavior: Overactivity, listlessness, harms others, sexually acts out, refuses to talk
Social Interaction: Withdrawn, clings excessively
Thinking: Mistrustful, distracted, problems concentrating
Physical Problems: Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other: Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

15 Months
Waves bye-bye
Is interested in all sounds around him
Puts block in cup
Uses vocalization to request objects and direct attention
Stoops and recovers

18 Months
Brings you item when asked (no pointing)
Says six words
Asks for familiar toys that are not around
Responds to "give me"
Walks backwards

2 Years
Uses spoon
Builds tower of 2 cubes
Combines 2 words
Follows 2-part directions
Kicks ball forward

Progress Notes

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3 – 5 Years

Texas Department of Health
Child Health Record
Preventive Health Visit

Family Profile and Health

___ No change in household since last visit
Child lives with:
___ Mother ___ Father ___ Stepparent ___ Grandparent ___ Other
Total adults living in home: ______
Total children living in home: ______
Primary caretaker for this child: ______
Relationship: ______
Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ___ P ___ F
Type of Developmental Screen:
Standardized Parent Questionnaire: ______
Standardized Observational Screen: ______
Other: ______
Further assessment needed: ___ Y ___ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: ___ Y ___ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Dental Care:

Physical Examination

Temp ______ Pulse ______ Resp ______
BP ______ Height ______ Weight ______
(%) ______ (%) ______ (%) ______

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat	**Neurologic:**			
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breast				

Additional documentation:

Client Information

Name: ______
DOB: ____/____/____ Age: ______ Sex: ______
SSN/Record No.: ______
Race/Ethnicity: ______
Informant/Relationship: ______
Medical Home: ______

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental* ___ Y ___ N
** If answered yes, further assessment needed.*
Usual Servings Per Day:
__ Dairy ___ Vegetables
__ Breads, cereal, rice, and pasta
__ Meat, poultry, fish, eggs, and dry beans
__ Fruits
WIC: __ Y __ N
Flouride Supplements: __ Y __ N
Vitamins: __ Y __ N

Sensory

Vision Screen: ___ Normal ___ Abnormal
Hearing Screen: ___ Normal ___ Abnormal
Hearing Screen Used: ___ Objective (audiometric) ___ Subjective

Health Education

Injury Prevention
__ Car safety restraints
__ Poisoning
__ Fire safety
__ Firearms
__ Street, water, bicycle safety
__ Scissors/sharp objects
__ Stranger safety
__ Teach telephone no. & address
__ Self-safety
__ Passive smoking

Behavior
__ Talk/read with child
__ Exploration
__ Limit television
__ Discipline, consistency

__ Toilet training
__ Social interaction
__ School readiness
__ Sex education

Health Promotion
__ Immunizations
__ Well-child care
__ Dental care, appointment
__ Family planning
__ Daycare

Nutrition
__ Healthy diet/snacks
__ Junk food
__ Iron-rich foods
__ Physical activity

Assessment

Plan

Dental referral made: __ Y __ N
WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead ______
Next appointment:

Date: ______ Signature/Title: ______ Signature/Title: ______

3 - 5 Years

If used for documentation: ______________________

Patient's Name: ______________________

Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, blinking, tearing

Nose/Mouth/Throat/Teeth: Nasal Congestions

Cardio/respiratory:	History of murmur, trouble with breathing, wheezing
Gastrointestinal:	Bowl movement frequency, soiling
Genitourniary:	Dysuria, discharge
Neuromuscular:	Seizures, coordination, gait
Musculoskeletal:	Fractures

Mental Health

The mental health assessment of this age also includes the developmental assessment and information from the family profile.

Feelings:	Out of control, angry, sad, fearful, sullen, anxious
Behavior:	Overactive, listlessness, harms others or property, sexually acts out, impulsive, frequently provokes other children, se f-abuses
Social Interaction:	Withdrawn, clings excessively, acts too young, communicates non-verbally rather than verbally
Thinking:	Mistrustful, distracted, easily frustrated
Physical Problems:	Low weight for age, weight loss, vomits, problem eating, lacks energy, sleeping problems
Other:	Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse

Development

3 Years	4 Years	5 Years
Brushes teeth with help	Puts on T-shirt	Brush teeth — no help
Tower of 6 cubes	Wiggles thumb	Copies +
Uses pronouns, I, you, me	Expresss needs, ideas in 3-6 word sentences	Carries on a conversation
Throws ball overhand	Balances on 1 foot, 2 sec.	Balances on 1 foot, 3 sec.

Progress Notes

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G.8 Child Health Record (6-10 Years) (2 Pages)

6 – 10 Years

Texas Department of Health
Child Health Record
Preventive Health Visit

Family Profile and Health

___ No change in household since last visit
Child lives with:
___ Mother ___ Father ___ Stepparent ___ Grandparent ___ Other
Total adults living in home: ______
Total children living in home: ______
Primary caretaker for this child: ______
Relationship: ______
Family's concerns/problems:

Mental Health

(+ indicates need for further assessment)

__ Sleep Problems
__ Behavior/problems
__ Relationship problems with parents, siblings, peers
__ Problems in school
Grade Level ______
__ Special education classes
__ No/excessive extracurricular activities
__ Substance abuse/use
__ Self-concept problems

Comments:
:

Child's Health

Allergies:
Does the system review note any problems or parent concerns: ___ Y ___ N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Dental Care/sealants:

Physical Examination

Temp ______ Pulse ______ Resp ______
BP ______ Height ______ Weight ______
(%) ______ (%) ______ (%) ______

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat	**Neurologic:**			
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breast (Tanner stage)				

Additional documentation:

Client Information

Name: ______
DOB: ____/____/____ Age: ______ Sex: ______
SSN/Record No.: ______
Race/Ethnicity: ______
Informant/Relationship: ______
Medical Home: ______

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental* ___ Y ___ N
** If answered yes, further assessment needed.*
Usual Servings Per Day:
__ Dairy ___ Vegetables ___ Fruit
__ Breads, cereal, rice, and pasta
__ Meat, poultry, fish, eggs, and dry beans

Sensory

Vision Screen: ___ Normal ___ Abnormal
Hearing Screen: ___ Normal ___ Abnormal
Hearing Screen Used: ___ Objective (audiometric) ___ Subjective

Health Education

Injury Prevention
__ Seat belt/auto safety
__ Bicycles/ATV
__ Athletics
__ Water safety
__ Smoke detectors
__ Firearm safety

Behavior
__ Substance abuse
__ Tobacco Use
__ Security
__ Discipline patterns
__ Responsibility
__ Communication/conflict resolution

Health Promotion
__ Limit TV viewing
__ Passive smoking
__ Regular exercise
__ Pubertal changes/sexuality
__ Dental care/sealants

Nutrition
__ Healthy diet/snacks
__ Junk food
__ Iron-rich foods

Assessment

Plan

Dental referral made: __ Y __ N
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Hct/Hgb ______ Lead ______
Next appointment:

Date: ______ Signature/Title: ______ Signature/Title: ______

6 - 10 Years

If used for documentation: ______________________

Patient's Name: ______________________

Date: ______________________

Key Elements

Systems Review

Skin: Rashes, infections

Ears: Hearing or ear problems

Eyes: Eye discharge, blinking, tearing

Nose/Mouth/Throat/Teeth: Nasal Congestions

Cardio/respiratory:	History of murmur, trouble with breathing, wheezing
Gastrointestinal:	Bowl movement frequency, problems/concerns, encopresis
Genitourniary:	Dysuria, pubescent changes, penile/vaginal discharge or spotting, enuresis
Neuromuscular:	Seizures
Musculoskeletal:	Fractures, sprains, sport injuries

Progress Notes

G.9 24-Hour Dietary Recall, Assessment for Infants (Birth–11 Months) (2 Pages)

Diet History (*Provide all answers except in shaded areas*) Dietary Recall and Assessment for Infants BIRTH through 11 MONTHS		Name:______________________________ DOB:__________________ Age:________	
Assessment Questions For Infants		Risk Conditions Defined	Code
All Infants: Is your infant following therapeutic diet/special feeding instructions?	Yes_ No_	Developmental, Sensory or Motor Delays Interfering with the Ability to Eat	362
Describe:____ Does your infant have any developmental feeding problems? Describe____	Yes_ No_	Disabilities that restrict the ability to chew or swallow food or require tube feeding to meet nutritional needs	
Breast-fed Infant (Total or Partial):		Infrequent Breastfeeding as Sole Source of Nutrients:	418
How many feedings in past 24 hours ___________Length _______		Totally breastfed (no formula/solids)	
		• younger than 2 mos. - less than 8 feedings in 24 hrs	
		• 2 months or older - less than 6 feedings in 24 hours	
		Breastfeeding/Potential Complications:	603
Problems with breastfeeding? ______________________________		• jaundice, weak/ineffective suck, latching difficulties	
How many wet diapers per day? ____________________________		• less than 6 wet diapers per day	
Formula-Fed Infant:		Feeding Cow's Milk	413
Brand/type of formula or milk: ____________________________			
__ Powder __ Concentrated __ Ready-to-Use		Inappropriate Infant Feeding:	411
		• feeding goat/sheep, imitation, or substitute milks	
Is formula iron fortified?	Yes_ No_	• formula feeding only	
If NO, is your infant taking iron drops?	Yes_ No_	• 0-6 months - feeding low iron formula w/o iron supp.	
How is the formula diluted and mixed?_______________________		Improper Dilution of Formula	415
Is anything added to the formula besides water?	Yes_ No_	Adding honey Adding corn syrup, sugar...	411 416
Bottle-Fed Infant, Breastmilk and/or Formula:		Inappropriate Infant Feeding	411
Number of bottles made at one time ________________________		Inadequate Amount, Nonbreastfed Only:	
Amount of breastmilk/formula in each bottle _________________		• 0-3 months - less than 20 oz. in 24 hours	
Amount of breastmilk/formula consumed at each feeding__________		• 4-5 months - less than 26 oz. in 24 hours	
Number of bottles consumed in 24 hours____________________		• 6-11 months - less than 24 oz. in 24 hours	
Total amount of breastmilk/formula consumed in 24 hours________		Excessive amount, Nonbreastfed Only:	
How long does one can of formula last?_____________________		• 0-4 months - more than 40 oz. in 24 hours	
		• 5-9 months - more than 36 oz. in 24 hours	
		• 10-11 months - more than 32 oz. in 24 hours	
		Lack of Sanitation in Preparation or Handling	417
Is water boiled before it is mixed with formula? What is done with leftover breastmilk/formula in the bottle?________ How are bottles/equipment cleaned?____________________ How are bottles of breastmilk/formula stored?________________	Yes_ No_	Younger than 3 months and water not boiled unsafe water no stove feeding formula that has been at room temperature longer than 2 hours, stored in refrigerator longer than 48 hours, or left from another feeding	
Do you... put the baby to bed with a bottle? prop the bottle? let the baby crawl or walk around with the bottle or use the bottle to pacify the baby? use the bottle to feed liquids other than breastmilk/formula/water?	 Yes_ No_ Yes_ No_ Yes_ No_ Yes_ No_	Inappropriate Use of Nursing Bottles yes to any	419
All Infants: Have any foods/beverages other than formula/breastmilk been introduced?___ If yes, during what month?__________________________________ Continue to the next section on the other side.		Early Introduction of Solid Foods • solids introduced before 4 months Inappropriate Infant Feeding • no solids introduced by 7 months	412 411
		No Dependable Source of Iron After 6 Months no iron-fortified formula, iron-fortified cereals, meats, or oral iron supplements	414
Recall taken by:__________________________________ Date:____________ Recall assessed by:________________________________			

Texas Department of Health WIC-42 Rev. 5/24/99

Name______________________________ Date________________

24-Hour Infant Diet Recall

What foods/beverages, other than breastmilk or formula, have you given the baby in the last 24 hours? (List amounts.)	No Dependable Source of Iron After 6 Months	414
	• no iron-fortified formula, iron-fortified cereals, meats, or oral iron supplements	
	Vegan Diets	402
	• no animal or dairy products	
	Highly Restrictive Diets	403
	• very low in calories, severely limits intake or important food sources of nutrients, restricts timing or combination of foods, or other high-risk patterns	
	Inappropriate Infant Feeding	411
Is your baby finger feeding or eating finger foods?...Yes ___ No ___	• 7-9 months – infant not beginning to finger feed	
	• fed or feeding foods that could cause choking	
	Inappropriate Infant Feeding	411
How are solid foods being fed to baby?__________________	• feeding solids in the bottle or infant feeder	
	• use a syringe-type feeder	
	• not using a spoon for solids	
Do you...	Feeding Foods Low in Essential Nutrients	416
give water? Yes___ No___ how much?___________	• more than four oz. of water per day	
give tea or coffee?... Yes___ No___	• any amount of tea, coffee, cola, or caffeine-containing foods	
give colas or other sweetened beverages?...... Yes___ No___	• any sweetened beverages or high-calorie foods	
give other high calorie non-nutritious foods? (corn syrup, sugar, or salt)........................... Yes___ No___		
	Inappropriate Infant Feeding	
give honey?... Yes___ No___	• give honey	411

WIC Health History for Infants

Please answer the following questions:		Comments (For Staff Use Only)	NV	Code
Was your infant born with any medical problems?	Yes__ No__			
Has your infant ever had any health problems?	Yes__ No__			
has your infant been the hospital (other than when born) or emergency room?	Yes__ No__			
Is infant on a special diet for medical reasons?	Yes__ No__			
Are there any foods that you limit, avoid, or do not give your infant for any reason?	Yes__ No__			
Is your infant taking any medications?	Yes__ No__			357
Has your infant had: surgery?	Yes__ No__			359
burns?	Yes__ No__			
serious injury?	Yes__ No__			
Do you give your infant: herbal medicine?	Yes__ No__	(Inappropriate or Excessive)		423
vitamins/minerals?	Yes__ No__	(Fluoride, Iron)		424
herbal tea?	Yes__ No__			
Do you have: a working stove?	Yes__ No__			
a working refrigerator?	Yes__ No__			
running water?	Yes__ No__			
Are you afraid that someone you know may injure or harm your infant?	Yes__ No__	National Domestic Violence Hotline, 800-799-7233		901
Where does your infant get health care; how long since last visit?				
Doctor:_______________________				
Shots:_______________________	__ 1-3 months? __ 4-6 months? __ 7-9 months?			
Clinic_______________________	__ 10-12 months?			

G

G.10 24-Hour Dietary Recall and Assessment for Children (1–4 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Children 1 Through 4 Years

Name ______________________

DOB ____________ **Age** ________

SSN/Record No. ________________

Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? ☐ Yes ☐ No

If yes, list: ______________________

*Does child have anemia? ☐ Yes ☐ No

*Does child have lead poisoning? ☐ Yes ☐ No

*Does child have chronic vomiting, diarrhea, or constipation? ☐ Yes ☐ No

If yes, list: ______________________

Resources

Working stove and refrigerator? ☐ Yes ☐ No

☐ WIC
☐ Meals in child care
☐ Summer food program
☐ Food Stamps
☐ Head Start
☐ Food pantry or soup kitchen

Do you need help in obtaining food? ☐ Yes ☐ No

Feeding Skills

Is child weaned from bottle by 18 months? ☐ Yes ☐ No

Is child able to feed self after 2 years? ☐ Yes ☐ No ☐ N/A

*Does child have any feeding problems? ☐ Yes ☐ No

Check all that apply:

☐ sucking ☐ chewing ☐ choking
☐ swallowing ☐ gagging ☐ other (specify): ______________

Dietary Practices

*Is child on a therapeutic or special diet? ☐ Yes ☐ No

If yes, describe: ______________ Prescribed by: ______________

*Any major food allergies? ☐ Yes ☐ No

If yes, list: ______________ Symptoms: ______________

*Any food groups refused or omitted? ☐ Yes ☐ No

If yes, list: ______________________

Does child eat dirt, clay, paint chips, or other non-foods? ☐ Yes ☐ No

Does child under 3 eat hot dogs, grapes, nuts, popcorn, or hard candies? ☐ Yes ☐ No ☐ N/A

Does child or family eat or avoid any special foods for religious or health reasons? ☐ Yes ☐ No

If yes, describe: ______________________

Health Habits

Hours of TV per day: ______________________

How many minutes per day is child physically active? ______________________

What type of activity? ______________________

How many meals given daily? ______________________

Are meals eaten with family? ☐ Yes ☐ No

Are snacks given? ☐ Yes ☐ No

If yes, list: ______________________

How many snacks per day, including beverages such as fruit juice, fruit drinks, or sodas? ______________

How often do you brush and floss child's teeth? ______________________

Encouraged to clean plate? ☐ Yes ☐ No

Vitamin/mineral pills? ☐ Yes ☐ No

If yes, list brand or type: ______________________

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: ______________________

Recall assessed by: ______________________ **Date:** ____________

E13-06-11656 Rev. 5/28/03

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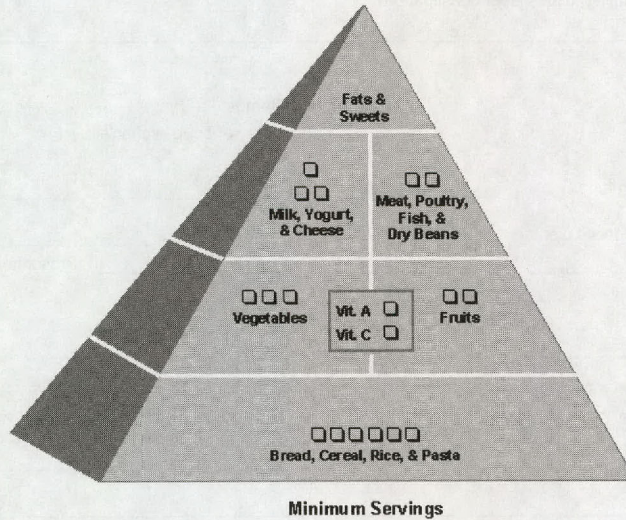
Texas Department of Health

Nutrition Education

- weaning from bottle
- ☐ foods that cause choking
- ☐ dental health
- ☐ whole milk only (< 2 yrs.)
- ☐ GI disturbances
- ☐ feeding skills
- ☐ obesity prevention/treatment
- ☐ healthy diet
- ☐ iron-rich foods
- ☐ inadequate/excessive intake of: ____________________
- ☐ pica / lead poisoning
- ☐ healthy snacks
- ☐ low-fat eating (> 2 yrs.) for heart health
- ☐ physical activity
- ☐ other: ____________________

Date: __________ Counseled by: ____________________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

E13-06-11656 Rev. 5/28/03

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Texas Department of Health

G.11 24-Hour Dietary Recall and Assessment for Children (5–9 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Children 5 Through 9 Years

Name ______________________

DOB ____________ Age ________

SSN/Record No. ______________

Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? ______ ☐ Yes ☐ No

If yes, list: ______________________

*Does child have anemia? ______ ☐ Yes ☐ No

*Does child have lead poisoning? ______ ☐ Yes ☐ No

*Does child have chronic vomiting, diarrhea, or constipation? ______ ☐ Yes ☐ No

If yes, list: ______________________

Resources

Working stove and refrigerator? ______ ☐ Yes ☐ No

☐ School breakfast

☐ School lunch

☐ Summer food program

☐ Food Stamps

☐ Food pantry or soup kitchen

Do you need help in obtaining food? ______ ☐ Yes ☐ No

Dietary Practices

*Is child on a therapeutic or special diet? ______ ☐ Yes ☐ No

If yes, describe: ____________ Prescribed by: ____________

GI problems with milk products? ______ ☐ Yes ☐ No

*Any major food allergies? ______ ☐ Yes ☐ No

If yes, list: ____________ Symptoms: ____________

*Any food groups refused? ______ ☐ Yes ☐ No

If yes, list: ______________________

Does child or family eat or avoid any special foods for religious or health reasons? ______ ☐ Yes ☐ No

If yes, describe: ______________________

Health Habits

Hours of TV per day: ______________________

How many minutes per day is child physically active? ______________________

What type of activity? ______________________

How many meals given daily? ______________________

Are meals eaten with family? ______ ☐ Yes ☐ No

Are snacks given? ______ ☐ Yes ☐ No

If yes, list: ______________________

How many snacks per day? ______________________

How often are the child's teeth brushed and flossed? ______________________

Encouraged to clean plate? ______ ☐ Yes ☐ No

Vitamin/mineral pills? ______ ☐ Yes ☐ No

If yes, list brand or type: ______________________

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: ______________________

Recall assessed by: ______________________ **Date:** ____________

ECH-14 Rev. 5/28/03

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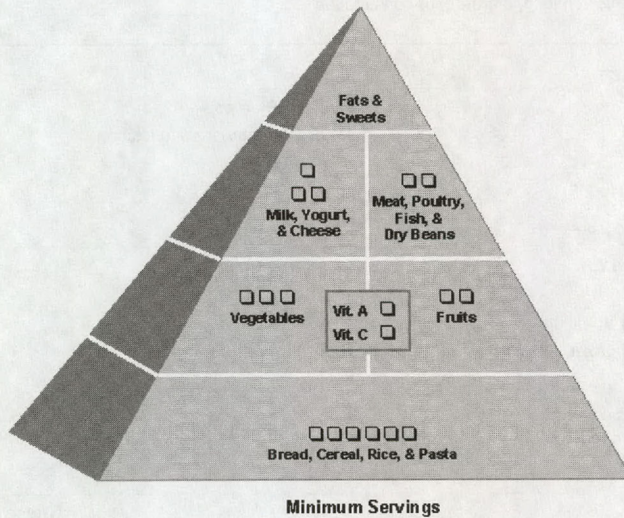
Texas Department of Health

Nutrition Education

physical activity
☐ iron-rich foods
☐ GI disturbances or problems with milk
☐ weight management
☐ healthy diet
☐ other: ____________________

☐ healthy snacks
☐ dental health
☐ low-fat eating for heart health
☐ inadequate/excessive intake of: ____________________

Date: __________ Counseled by: ____________________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

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G.12 24-Hour Dietary Recall and Assessment for Children (10–20 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Ages 10 Through 20 Years (Nonpregnant)

Name ____________
DOB ____________ Age ________
SSN/Record No. ____________
Required for Child / Teen Health

Medical Risks

*Is child or teen underweight or overweight, or does child or teen have poor growth? ________ ☐ Yes ☐ No
If yes, list: ____________
*Does child or teen have anemia? ________ ☐ Yes ☐ No
*Does child or teen have lead poisoning? ________ ☐ Yes ☐ No
*Does child or teen have chronic vomiting, diarrhea, or constipation? ________ ☐ Yes ☐ No
If yes, list: ____________

Resources

Working stove and refrigerator? ________ ☐ Yes ☐ No
☐ School breakfast ☐ Food Stamps
☐ School lunch ☐ Food pantry or soup kitchen
☐ Summer food program
Do you need help in obtaining food? ________ ☐ Yes ☐ No

Weight-Loss Practices

How do you feel about your weight? ________ ☐ Good ☐ Bad
*Any restrictive dieting practices? ________ ☐ Yes ☐ No
Check all that apply:
☐ Skipped meals ☐ Vomiting ☐ Excessive exercise
☐ Diet pills ☐ Laxatives
Diet supplements or fad diets? ________ ☐ Yes ☐ No
If yes, describe: ____________
Do you feel your eating is out of control? ________ ☐ Yes ☐ No

Dietary Practices

*Any therapeutic/special diet? ________ ☐ Yes ☐ No
If yes, describe: ____________ Prescribed by: ____________
GI problems with milk products? ________ ☐ Yes ☐ No
*Any major food allergies? ________ ☐ Yes ☐ No
If yes, list: ____________ Symptoms: ____________
*Any food groups refused? ________ ☐ Yes ☐ No
If yes, list: ____________
Do you eat or avoid any special foods for religious or health reasons? ________ ☐ Yes ☐ No
If yes, describe: ____________

Health Habits

Hours of TV per day: ____________
How many minutes per day are you physically active? ____________
How many meals given daily? ____________
Snacks eaten daily, including beverages such as sports drinks or sodas? ________ ☐ Yes ☐ No
If yes, list: ____________
How many snacks per day? ____________
"Fast food" eaten: ____________
Alcohol/tobacco/street drugs? ________ ☐ Yes ☐ No
If yes, what kind? ________ How often? ________ How much? ________
Vitamin/mineral pills? ________ ☐ Yes ☐ No
If yes, list brand or type: ☐ Yes ☐ No

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: ____________

Recall assessed by: ____________ **Date:** ________

ECH-15Rev. 5/15/03 Rev. 5/28/03

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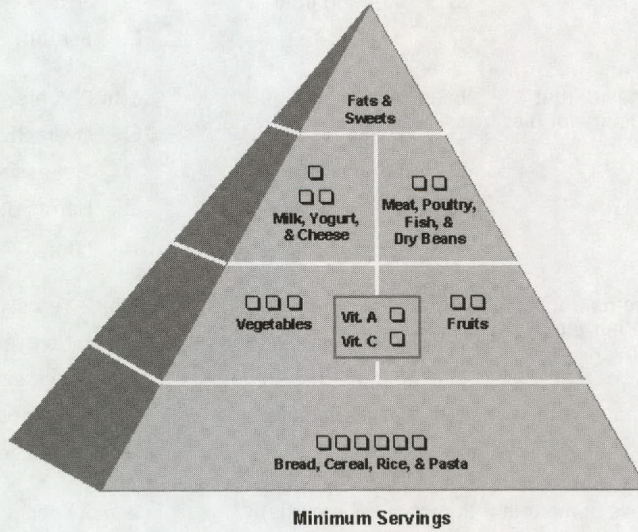
Counseled on

healthy diet	☐ healthy "fast food" choices	☐ smoking/alcohol/drugs
☐ weight mangement / fad diets	☐ iron-rich foods	☐ GI disturbances or problems with milk
☐ nutrition for sports	☐ calcium-rich foods	☐ low-fat eating for heart health
☐ eating regular meals 3x/day	☐ physical activity	☐ physical activity
☐ healthy snacks	☐ inadequate/excessive intake of: ________	
☐ other: ________		

Date: ________ Counseled by: ________



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

ECH-15Rev. 5/15/03 Rev. 5/28/03

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G.13 Mental Health Interview Tool/Referral Form (Ages 0–2 Years)

Mental Health Interview Tool/Referral Form

Ages 0 to 2

Child's Name: ____________________

Birth Date: ____________________

Date: ____________________

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings: Does your child display feelings that concern you or seem out of the ordinary?

Infants
- ❑ Anxious
- ❑ Cries excessively
- ❑ Cries too little

1 to 2 Years
- ❑ Irritable
- ❑ Angry
- ❑ Sad
- ❑ Fearful
- ❑ Sullen
- ❑ Anxious
- ❑ Cries excessively
- ❑ Cries too little

Behavior: Does your child display behavior that concerns you or seems out of the ordinary for his/her age?

Infants
- ❑ Overactive
- ❑ Listlessness

1 to 2 Years
- ❑ Overactive
- ❑ Listlessness
- ❑ Harms others
- ❑ Frequent temper tantrums

Social Interaction: Do you have concerns about how your child gets along with you? Other family members or adults? Siblings?

Infants
- ❑ No eye contact or smile
- ❑ Stiffens and arches
- ❑ Not responsive

1 to 2 Years
- ❑ * No eye contact or smile
- ❑ Clings excessively
- ❑ Not responsive
- ❑ Language delay

Thinking: Do you think your child's development is normal for age?

Infants (> 8 months)
- ❑ No communication skills (pointing to request an object) or efforts to make words

1 to 2 Year
- ❑ Mistrustful
- ❑ Problems concentrating or paying attention

Physical Problems: Do you have any concerns about your child's physical health? If physical problems exist, have they been medically evaluated?

Infants to 2 Years
- ❑ Low weight or weight loss
- ❑ Frequent vomiting
- ❑ Eating problem (poor appetite, eats nonfoods)
- ❑ Sleeping problem (frequent night waking)
- ❑ Lethargic

Other: Are there any situations which are causing your family particular stress at this time?
Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse?
If yes, what form, when, treatment initiated, etc.?
Did the mother of this child use drugs or drink alcohol during the pregnancy?

Comments:

Signature/Title: ____________________

G.14 Mental Health Interview Tool/Referral Form (Ages 0–2 Years) (Spanish)

Instrumento para la Evaluación de la Salud Mental y Formulario para Tratamiento con un Especialista

Nombre del Niño:________________________
Fecha de Nacimiento: ____________________
Fecha: _____________________________

De Recién Nacido a 2 Años de Edad

*Para los niños que pertenecen a este grupo usted obtendrá información de los padres/personas encargadas y de sus propias observaciones del bebé. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos puede indicar que el niño está en una crisis, y se debe haces un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos: ¿Muestra su niño sentimientos que le preocupan o que parezcan extraños?

Recién Nacidos
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

De 1 a 2 Años
- ❑ Se irrita
- ❑ Se enoja
- ❑ Está triste
- ❑ Tiene miedo
- ❑ Malhumorado
- ❑ Ansioso
- ❑ Llora demasiado
- ❑ Llora muy poco

Comportamientos: ¿Muestra su niño un compartamiento que le preocupa o que parezca extraño para su edad?

Recién Nacidos
- ❑ Es demasiado activo
- ❑ Es indiferente

De 1 a 2 Años
- ❑ Es demasiado activo
- ❑ Es indiferente
- ❑ Lastima a los demás
- ❑ Hace berrinches temperamentales frecuentemente

Interacciones Sociales: ¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia o adultos? ¿Con sus hermanos?

Recién Nacidos
- ❑ No ve a los ojos ni sonríe
- ❑ Se pone tieso y se dobla arqueando la espalada
- ❑ No muestra mucho interés

De 1 a 2 Años
- ❑ *No ve a los ojos ni sonríe
- ❑ Se pega a usted excesivamente
- ❑ No muestra mucho interés
- ❑ Está atrasado en el lenguaje

Pensamientos: ¿Cree usted que el desarrollo de su niño es normal para su edad?

<u>Recién Nacidos</u> (>8 meses)
- ❑ No tiene habilidad para comunicarse (apunta para pedir un objeto) ni se esfuerza para decir palabras

De 1 a 2 Años
- ❑ No tiene confianza
- ❑ Tiene problemas para concentrarse o para poner atención

Problemas Físicos: ¿Se preocupa sobre la salud física de su niño? Si existen problemas físicos, ¿han sido evaluados médicamente?

Recién Nacidos a 2 Años
- ❑ Peso bajo o pérdida de peso
- ❑ Se vomita frecuentemente
- ❑ Tiene problemas para comer (poco apetito, come alimentos que no son saludables)
- ❑ Tiene problemas para dormir (se despierta frecuentemente por las noches)
- ❑ Es letárgico

Otra: ¿Hay alguna situación que le esté causando a su familia cierta tensión ahora?
¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional?
Si contesta sí, ¿de qué manera?, ¿cuándo?, ¿se ha comenzado algún tratamiento?, etc.
¿Usó la mamá de este niño drogas o tomó bebidas alcohólicas durante su embarazo?

Comentarios:

Firma/Titulo de su puesto:____

TDH/OLS/6-395/10-96

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G.15 Mental Health Interview Tool/Referral Form (Ages 3–9 Years)

Mental Health Interview Tool/Referral Form

Ages 3 to 9

Child's Name: ______________________
Birth Date: ______________________
Date: ______________________

*For this age group you will obtain information from the parent/caregiver and from your own observations of the child's behavior. If possible, interview the parent alone when asking questions about sexual or physical abuse. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Does your child display feelings that concern you or seem out of the ordinary for age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Excessively guilty
- ❑ Lack of remorse
- ❑ Irritable, angers or temper tantrums easily
- ❑ Sullen
- ❑ Fearful or anxious

Behavior:

Does your child frequently display behavior that seems out of the ordinary for age?

- ❑ Problems in school
- ❑ * Harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Self-destructive
- ❑ * Has been in trouble with the police (older child)

Social Interaction:

Do you have concerns about how child gets along with you, other family members, playmates, other adults?

- ❑ Withdraws including no eye contact
- ❑ Clings excessively
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Severe or frequent tantrums
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school
- ❑ Prefers to be alone

Thinking:

Have you noticed any of the following to be a problem for your child?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ * Bizarre thoughts
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there (excluding imaginary friends in younger children)
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death
- ❑ * Frequent memory loss
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Daytime wetting
- ❑ Soils pants
- ❑ Refusal to eat
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking
- ❑ Vomits frequently
- ❑ Frequent stomachaches
- ❑ Lacks energy

Other:

Is this child accident-prone?
Are there any situations that are causing your family particular stress?
Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.
* Is this child at risk for out-of-home placement because of behavior problems?

Comments:

Signature/Title: ____

G.16 Mental Health Interview Tool/Referral Form (Ages 3–9 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y Formulario para Tratamiento con un Especialista De 3 a 9 Años de Edad

Nombre del Niño:____________________

Fecha de Nacimiento: ____________________

Fecha: ____________________

*Para los niños que pertenecen a este grupo usted obtendrá informatción de los padres/tudor y de sus propias observaciones del comportamiento del niño. Si es posible, entreviste a los padres solos cuando haga preguntas sobre el abuso sexual o físico. Marque las características que le preocupen. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Muestra su niño sentimientos que le preocupan o que parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Muestra mucha culpabilidad
- ❑ No tiene remordimiento
- ❑ Se irrita, enoja, o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Tiene miedo o está ansioso

Comportamiento:

¿Muestra su niño frecuentemente un comportamiento que le parezca extraño para su edad?

- ❑ Problemas en la escuela
- ❑ *Lastima a otros niños o a animales
- ❑ No tien interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Tiene un comportamiento de autodestrucción
- ❑ *Ha tenido problemas con la policía (con otro niño)

Interacción Sociales:

¿Se preocupa sobre cómo se lleva su niño con usted? ¿Con otros miembros de la familia? ¿Con otros adultos? o ¿Con sus amigos de juego?

- ❑ Se retira sin dirgir la mirada a los ojos
- ❑ Se pega a usted excesivamente
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Hace berrinches temperamentales fuertes o frecuentemente
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela
- ❑ Prefiere estar solo

Pensamientos:

¿Ha notado si alguno de los siguientes es un problem para su niño?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ *Tiene pensamientos raros
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí (excepto los amigos) imaginarios en niños más pequeños
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte
- ❑ *Pierde la memoria frecuentemente
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ Se orina durante el día
- ❑ Se ensucia
- ❑ Se niega a comer
- ❑ Tiene dolores de cabeza
- ❑ Pérdida o aumento de peso excesivo
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano
- ❑ Se vomita frecuentemente
- ❑ Tiene dolores de estómago frecuentemente
- ❑ No tiene energía

Otros:

¿Tiende este niño a tener accidentes? ¿Hay alguna situación que le esté causando a su familia tensión en particular? ¿Ha sido este niño o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí. ¿En que forma? ¿Cuando? ¿Tipo de tratamiento?, etc. *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

Comentarios:

Firma/Titulo de su puesto:____

TDH/OLS/6-396/11-96

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G.17 Mental Health Interview Tool/Referral Form (Ages 10–12 Years)

Mental Health Interview Tool/Referral Form

Ages 10 to 12

Child's Name: ____________________

Birth Date: ____________________

Date: ____________________

Both child and parent will be able to provide information, and it is important to incorporate the child into the interview process. In each section, a sample question is directed toward the parent. To the extent possible, elicit the child's perception of the parent's response with a question such as "Do you agree with what your Mom is saying?" It may be useful to allow time for discussion with the caregiver alone. The child should be interviewed alone when asking questions about sexual or physical abuse and about substance abuse. Circle items of concern.
** The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation..*

Feelings:

Does your child (do you) have feelings that concern you or seem out of the ordinary for age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Guilty
- ❑ Irritable or angers easily
- ❑ Sullen
- ❑ Fearful or anxious
- ❑ Bored

Behavior:

Does your child (do you) behave in ways that seems out of the ordinary for age?

- ❑ Problems in school
- ❑ * Threatens or harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Has been in trouble with the police
- ❑ * Self-destructive

Social Interaction:

Do you have concerns about how your child (you) gets along with family members, other adults or children?

- ❑ Prefers to be alone
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for your child (you)?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death or suicide
- ❑ * Frequent memory loss
- ❑ * Bizarre thoughts
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Lacks energy
- ❑ Uses laxatives
- ❑ Vomits frequently
- ❑ Food refusal, secretive eating
- ❑ Frequent stomachaches
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Is this child (are you) accident-prone?
Are there any situations that are causing your family particular stress?
Has this child or his/her parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- ❑ * Is this child at risk for out-of-home placement because of behavior problems?
- ❑ Has the child (have you) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- ❑ Has been identified as a problem

Comments:

Signature/Title: ____________________

G.18 Mental Health Interview Tool/Referral Form (Ages 10–12 Years) (Spanish)

Instrumento para la Entrevista de la Salud Mental y Formulario para Tratamiento con un Especialista De 10 a 12 Años de Edad

Nombre del Niño:____________________

Fecha de Nacimiento: ________________

Fecha: ________________________

*Ambos, el niño y los padres podrán proveer información, y es importante incorporar al niño en la entrevista. En cada sección, se le hace una pregunta ejemplar a los padres. Obtenga, lo mejor que pueda, la percepción del niño sobre la respuesta de sus padres con una pregunta como "¿Estás de acuerdo con lo que dice tu mamá?" Sería conveniente dedicar tiempo para hablar solamente con el tutor del niño. Se debe entrevistar al niño solo cuando se hagan preguntas sobre el abuso sexual o físico y sobre el abuso de sustancias como las drogas y las bebidas alcohólicas. Marque las características que le preocupan. *La presencia de alguno de estos síntomas o comportamientos pueden indicar que el niño está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su niño (tienes) sentimientos que le (te) preocupupan o que parezcan extraños para su (tu) edad?

- ❑ Es inquieto
- ❑ Está triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Tien miedo o está ansioso
- ❑ Se aburre

Interacción Sociales:

¿Se preocupa(s) sobre cómo se (te) lleva(s) su niño con los miembros de la familia? ¿Con otros adultos? ¿O niños?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer o tener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Problemas Físicos:

¿Le (te) preocupa alguna de las siguientes señales físicas? ¿Han sido estas evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come a escondidas
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, se despierta seguido por la noche

Comportamiento:

¿Se (Te) comporta(s) de una manera que parecen extrañas para su (tu) edad?

- ❑ Problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a animales
- ❑ No tiene interés en cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con juguetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Enciende fuegos
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Pensamientos:

¿Ha(s) notado si alguno de los siguientes es un problem para su niño (ti)?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ *Habla sobre la muerte o el suicidio
- ❑ *Pierde la memoria frecuentemente
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Otros:

¿Es este niño (Eres) propenso a tener accidentes? ¿Hay alguna situación que le esté causando a su (tu) familia tensión en particular? ¿Ha sido este niño (Has sido tu) o sus padres sujetos a la negligencia, o al abuso físico, sexual o emocional? Si, sí, ¿Que tipo?, ¿Cuándo?, ¿Tipo de tratamiento?

- ❑ *¿Corre el riesgo su niño de ser llevado a otro lugar fuera de casa por problemas de comportamiento?
- ❑ ¿Ha sido este niño tratado por problemas de salud mental o por el abuso de sustancias como drogas y bebidas alcohólicas?

Preguntas Sobre el Abuso de Sustancias:

(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el abuso de sustancias como drogas y bebidas alcóholicas.)

- ❑ Ha sido identificado como un problema

Comentarios:

Firma/Titulo de su puesto:____________________________________

TDH/OLS/6-397/11-96

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G.19 Mental Health Interview Tool/Referral Form (Ages 13–20 Years)

Mental Health Interview Tool/Referral Form

Ages 13 to 20

Child's Name: ____________________

Birth Date: ____________________

Date: ____________________

*You may begin with a joint interview or begin with separate interviews with the parent/caregiver and adolescent. It is preferable to interview the adolescent first. Circle items of concern. * The presence of any of these symptoms or behaviors may signal that the child is in crisis, and efforts should be made to secure prompt evaluation.*

Feelings:

Do you (does your teen) have feelings that concern you or seem out of the ordinary for (their) age?

- ❑ Restless
- ❑ Sad or cries easily
- ❑ Guilty
- ❑ Irritable or angers easily
- ❑ Sullen
- ❑ Fearful or anxious
- ❑ Bored

Behavior:

Do you (does your child) behave in ways that seems out of the ordinary for your (their) age?

- ❑ Problems at school or work
- ❑ * Threatens or harms other children or animals
- ❑ Lacks interest in things s/he used to enjoy
- ❑ Engages in sexual play with others, toys, animals
- ❑ * Destroys possessions or other property
- ❑ Steals
- ❑ Refuses to talk
- ❑ * Sets fires
- ❑ Overactive
- ❑ * Has been in trouble with the police
- ❑ * Self-destructive

Social Interaction:

Do you have concerns about how (you) your child gets along with family members, other adults, or peers?

- ❑ Prefers to be alone
- ❑ Difficulty making and keeping friends
- ❑ Defiant, a discipline problem
- ❑ Aggressive
- ❑ Argues excessively
- ❑ Refuses to go to school

Thinking:

Have you noticed any of the following to be a problem for you (your child)?

- ❑ * Frequently confused
- ❑ Daydreams excessively
- ❑ Distracted, doesn't pay attention
- ❑ Mistrustful
- ❑ * Sees or hears things that are not there
- ❑ Blames others for his/her misdeeds or thoughts
- ❑ * Talks about death or suicide
- ❑ * Frequent memory loss
- ❑ * Bizarre thoughts
- ❑ Schoolwork is slipping (grades going down)

Physical Problems:

Do you have any concerns about the following physical signs? Has this been evaluated?

- ❑ Lacks energy
- ❑ Uses laxatives
- ❑ Vomits frequently
- ❑ Food refusal, secretive eating
- ❑ Frequent stomachaches
- ❑ Headaches
- ❑ Excessive weight loss or gain
- ❑ Sleep problems, nightmares, sleep-walking, early waking, frequent night waking

Other:

Are you (is this child) accident-prone?
Are there any situations that are causing your family particular stress?
Have you (has this child) or your (his/her) parents been subject to neglect, physical, sexual or emotional abuse? If yes, what type, when, treatment, etc.

- ❑ * Are you (is this child) at risk for out-of-home placement because of behavior problems?
- ❑ Have you (has this child) been treated for mental health problems or substance abuse?

Substance Abuse Questions:

(May want to use screens such as the TACE, CAGE, MAST to obtain information concerning substance abuse.)

- ❑ Has been identified as a problem

Comments:

Signature/Title: ____________________

G.20 Mental Health Interview Tool/Referral Form (Ages 13–20 Years) (Spanish)

Instrumento para la Entrevista sobre la Salud Mental/
Formulario para Tratamiento con un Especialista
De 13 a 20 Años

Nombre del Adolescente:_______________
Fecha de Nacimiento: _________________
Fecha: ___________________________

Para los Padres: *Usted puede empezar con una entrevista con ambos el tutor y el adolescente. Es preferible que entreviste al adolescente primero. Marque las características que le preocupen. * La presencia de alguno de estos síntomas o comportamientos puede indicar que el adolescente está pasando por una crisis, y se debe hacer un esfuerzo para asegurar que se le evalúe pronto.*

Sentimientos:

¿Tiene su adolescente sentimientos que le preocupan o que le parezcan extraños para su edad?

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Se irrita o enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo o ansiedad
- ❑ Se aburre

Comportamiento:

¿Se comporta su adolescente de una manera que parece extraña para su edad?

- ❑ Tiene problemas en la escuela o en el trabajo
- ❑ *Amenaza o lastima a otros niños o a animales
- ❑ No le interesan las cosas que antes disfrutaba
- ❑ Participa en juegos sexuales con jugetes, animales, o con los demás
- ❑ *Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ *Provoca incendios
- ❑ Es demasiado activo
- ❑ *Ha tenido problemas con la policía
- ❑ *Tiene un comportamiento de autodestrucción

Interacciones Sociales:

¿Le preocupan cómo se lleva su adolescente con los miembros de la familia? ¿con otros adultos? ¿con su grupo social?

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, un problema de disciplina
- ❑ Es agresivo
- ❑ Discute demasiado
- ❑ Se niega a ir a la escuela

Pensamientos:

¿Ha notado si alguno de los siguientes es un problema para su adolescente?

- ❑ *Se confunde frecuentemente
- ❑ Sueña despierto demasiado
- ❑ Se distrae, no pone atención
- ❑ Es desconfiado
- ❑ *Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo malo que hizo o por sus pensamientos
- ❑ *Habla sobre la muerte el suicidio
- ❑ *Frecuentemente pierde la memoria
- ❑ *Tiene pensamientos raros
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)

Problemas Físicos:

¿Le preocupan algunas de las siguientes señales físicas? ¿Han sido evaluadas?

- ❑ No tiene energía
- ❑ Usa laxantes
- ❑ Se vomita frecuentemente
- ❑ Se niega a comer, come en secreto
- ❑ Tiene dolores de estómago frecuentemente
- ❑ Tiene dolores de cabeza
- ❑ Ha perdido o aumentado peso excesivamente
- ❑ Tiene problemas para dormir, pesadillas, sonambulismo, se despierta temprano, frecuentemente camina en la noche

Otros:

¿Tiende a tener accidentes? ¿Hay alguna situación que le esté causando a su familia cierta tensión? ¿Ha sido es adolescente o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma? ¿cuándo? ¿tipo de tratamiento?, etc.

* ¿Corre el riesgo de ser llevado a otro lugar fuera de casa por problemas de comportamiento?

¿Ha sido tratado por problemas de la salud mental o por el abuso de sustancias como bebidas alcohólicas o drogas?

Preguntas sobre el abuso de sustancias: *(Tal vez quiera usar pruebas de detección como TACE, CAGE, MAST para obtener información sobre el uso de sustancias.)*

- ❑ El abuso de sustancias como bebidas alcohólicas y drogas ha sido identificado como un problema.

Comentarios:

Firma/Titulo de su puesto:______________________________

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G.21 Mental Health Parent Questionnaire (Ages Birth–2 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages Birth to 2 Years

Child's Name: ____________________________
Birth Date: ____________________________
Today's Date: ____________________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings

Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Fearful	❑ Is irritable	❑ Fearful
❑ Cries too much	❑ Is angry	❑ Cries too little
❑ Cries too little	❑ Is sad	❑ Cries too much
	❑ Is sullen	

Behavior

Does your child do things that concern you or seem strange for their age? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Is overactive	❑ Is overactive	❑ Harms others
❑ Is listless (has little energy)	❑ Is listless (has little energy)	❑ Has temper tantrums often

Social Interaction

Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No
With other family members or adults? ❑ Yes ❑ No
With brothers and sisters? ❑ Yes ❑ No

Infants	1 to 2 Years	
❑ Does not make eye contact or smile	❑ Does not make eye contact or smile	❑ Does not respond to you
❑ Stiffens and arches back	❑ Clings to you too much	❑ Does not say any words yet
❑ Does not respond to you		

Thinking

Do you think your child is as bright and thinks as clearly as others their age? ❑ Yes ❑ No

Infants	1 to 2 Years
❑ (>8 months) Does not point to or ask for things or try to make words	❑ Does not trust others
	❑ Has problems concentrating or paying attention

Physicals	Problems	
		Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No
		Infants to 2 Years ❑ Is low weight or has a lot of weight ❑ Vomits (throws up) often ❑ Has eating problems (poor appetite, eats non-foods) ❑ Has sleeping problems (wakes a lot at night) ❑ Has little energy

Other	
	Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ________________ When? ________ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Did the mother of this child use drugs or alcohol during the pregnancy? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: ____________ Signature: ____

Relation to patient: ____

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G.22 Mental Health Questionnaire (Ages Birth–2 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres

Nombre del Niño: ____________________

Fecha de Nacimiento: ____________________

Fecha: ____________________

De Recién Nacido a 2 Años de Edad

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su bebé. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su bebé. Favor de marcar todas las características abajo que son ciertas para su bebé. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su bebé sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años	
❑ Siente miedo	❑ Es de mal carácter	❑ Siente miedo
❑ Llora mucho	❑ Es enojón	❑ Llora muy poco
❑ Llora muy poco	❑ Es triste	❑ Llora mucho
	❑ Es malhumorado	

COMPORTAMIENTO

¿Hace su bebé cosas que le preocupan o que parezcan extrañas para su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ Es demasiado activo	❑ Es demasiado activo
❑ Es indiferente (tiene poca energía)	❑ Es indiferente (tiene poca energía)
	❑ Lastima a otros
	❑ Hace berrinches frecuentemente

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su bebé con usted? ❑ Sí ❑ No
¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No
¿Con sus hermanos o hermanas? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ No ve a los ojos ni sonríe	❑ No ve a los ojos ni sonríe
❑ Se pone tieso y se dobla arqueando la espalda	❑ La mayoría del tiempo no se le despega
❑ No le responde	❑ No le responde
	❑ Todavía no dice ninguna palabra

PENSAMIENTOS

¿Piensa usted que su nino es tan inteligente y que piensa tan claramente como otros niños de su edad? ❑ Sí ❑ No

Bebés	De 1 a 2 Años
❑ (>8 meses) No pide ni senala a las cosas o trata de decir palabras	❑ No le tiene confianza a otros
	❑ Tiene problemas para concentrarse y poner atención

PROBLEMAS FISICOS	¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No Si usted piensa que su niño tiene un problema de salud, ¿lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No
	De recién nacidos a 2 Años ❑ Es de peso bajo o ha perdido mucho peso ❑ Se vomita frecuentemente ❑ Tiene problemas para comer (muy poco apetito, come alimentos que no son saludables) ❑ Tiene problemas para dormir (se despierta mucho durante la noche) ❑ Tiene muy poca energía
OTROS	¿Hay algo que le esté causando tensión a su familia ahora? ❑ Sí ❑ No ¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físicos, sexual o emocional? Si sí, ¿en qué forma?________ ¿Cuándo?________ ❑ Sí ❑ No ¿Empezó el tratamiento? ❑ Sí ❑ No ¿Usó drogas o tomó bebidas alcohólicas durante su embarazo la mamá de este niño? ❑ Sí ❑ No

Comentarios: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:____________ Firma:______________________________

Parentesco con el paciente:______________________________

BIRTH-2Y.MH2 (9-25-96)
TDH/0LS/6-399/10-96

G

G.23 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 3 to 9 Years

Child's Name: ______________________

Birth Date: ______________________

Today's Date: ______________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child show feelings that concern you or seem strange for their age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is overly guilty ❑ Lacks remorse	❑ Is irritable, angers or temper tantrums easily ❑ Is sullen ❑ Fearful

Behavior	Does your child do things that seem strange for their age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Plays sexual games with others, toys, animals ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is over-active ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child gets along with you? ❑ Yes ❑ No With other family members or adults? ❑ Yes ❑ No With playmates? ❑ Yes ❑ No	
	❑ Withdraws and does not look into peoples' eyes ❑ Clings to you too much ❑ Has a hard time making and keeping friends ❑ Is defiant, has a disciplinary problem ❑ Severe or frequent tantrums	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school ❑ Prefers to be alone

Thinking	Are any of these a problem for your child? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death a lot ❑ Often cannot remember things

Physical Problems		
	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child may have a health problem, has he/she seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Has daytime wetting ❑ Soils pants ❑ Will not eat ❑ Has headaches ❑ Has lost or gained a lot of weight	❑ Has sleeping problems, nightmares, sleep-walking, early waking ❑ Vomits (throws up) often ❑ Has stomach aches often ❑ Lacks energy

Other	
	Is this child accident-prone? ❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________ When? ________ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Is this child at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: __________ Signature: ______________________________

Relation to patient: ______________________________

G

G.24 Mental Health Parent Questionnaire (Ages 3–9 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 3 a 9 Años de Edad

Nombre del Niño: ____________________

Fecha de Nacimiento: ____________________

Fecha: ____________________

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problemática que tenga su niño. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que sean ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente muy culpable
- ❑ No tiene remordimiento
- ❑ Es de mal carácter, enojón o hace berrinches temperamentales fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Juega juegos sexuales con otros niños, juguetes, o animales
- ❑ Destruye cosas personales u ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No

¿Con otros miembros de la familia o adultos? ❑ Sí ❑ No

¿Con sus compañeros de juego? ❑ Sí ❑ No

- ❑ Se aleja y no ve a nadie a los ojos
- ❑ La mayoría del tiempo no se le despega
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Hace berrinches tempermentales fuertes o frecuentemente
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela
- ❑ Prefiere estar solo

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte
- ❑ Frecuentemente no se acuerda de cosas

PROBLEMAS FISICOS	¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No Si usted piensa que su niño tiene un problema de salud, ¿Lo ha llevado a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No
	❑ Se orina durante el día ❑ Ensucia sus pantalones ❑ No quiere comer ❑ Tiene dolores de cabeza ❑ Ha perdido o aumentado mucho de peso ❑ Tiene problemas para dormir, pesadillas, se despierta temprano y sonámbulo ❑ Se vomita frecuentemente ❑ Tiene dolores de estómago frecuentemente ❑ No tiene energía
OTROS	¿Es propenso este niño a tener accidentes? ❑ Sí ❑ No ¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No ¿Ha estado este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma?________________ ❑ Sí ❑ No ¿Cuándo? __________ ¿Empezó el tratamiento? ❑ Sí ❑ No ¿Corre el riesgo este niño de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

Fecha:______________ Firma:________________________________

Parentesco con el paciente:________________________________

3YR-9YR.MH2 (9-25-96)
TDH/OLS/6-400/10-96

G

G.25 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 10 to 12 Years

Child's Name: ______________________

Birth Date: ______________________

Today's Date: ______________________

To the Parent: *If you will assist us by filling out this form, we can help you find your child's strengths and any problem areas, too. Your answers will help us to know if we need to talk with you and find out more about your child. Please check all items below that are true for your child. Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Does your child (do you) show feelings that concern you or seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Is restless ❑ Is sad or cries easily ❑ Is guilty ❑ Is irritable or angers easily	❑ Is sullen ❑ Is fearful ❑ Is bored

Behavior	Does your child (do you) often do things that seem strange for their (your) age? ❑ Yes ❑ No	
	❑ Has problems in school ❑ Threatens or harms other children or animals ❑ Lacks interest in things s/he used to enjoy ❑ Is involved in sexual activity ❑ Destroys possessions or other property ❑ Steals	❑ Refuses to talk ❑ Sets fires ❑ Is overactive ❑ Hurts himself or herself ❑ Has been in trouble with the police

Social Interaction	Do you have any concerns about how your child (you) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With other children? ❑ Yes ❑ No	
	❑ Prefers to be alone ❑ Has a hard time making and keeping friends ❑ Is defiant, a disciplinary problem	❑ Picks on others a lot or often gets into fights (hitting, etc.) ❑ Argues too much ❑ Will not go to school

Thinking	Are any of these a problem for your child (you)? ❑ Yes ❑ No	
	❑ Is frequently confused (does not understand what is going on) ❑ Daydreams a lot ❑ Is distracted, doesn't pay attention ❑ Has very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Does not trust others ❑ Sees or hears things that are not there ❑ Blames others for his/her misdeeds or thoughts ❑ Talks about death or suicide a lot ❑ Often cannot remember things

Physical Problems		
	Do you have any concerns about these things? ❑ Yes ❑ No If you think your child (you) may have a health problem, has he/she (have you) seen a doctor or nurse about the problem? ❑ Yes ❑ No	
	❑ Lacks energy ❑ Uses laxatives ❑ Vomits (throws up) often ❑ Won't eat in front of people, sneaks food later ❑ Has stomach aches often	❑ Has headaches ❑ Has lost or gained a lot of weight ❑ Has sleeping problems, nightmares, sleep-walking, early waking, frequent night waking

Other	
	Is your child (you) accident-prone? ❑ Yes ❑ No Is anything causing your family stress right now? ❑ Yes ❑ No Has this child or his/her parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ______ When? ______ ❑ Yes ❑ No Treatment initiated? ❑ Yes ❑ No Is this child (are you) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No Does your child (do you) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No Has this child (have you) been treated for mental health problems or substance abuse? ❑ Yes ❑ No

Comments: *(Please write anything else you want us to know about in this space.)*

Date: __________ Signature: ______________________________

Relation to patient: ______________________________

G

G.26 Mental Health Parent Questionnaire (Ages 10–12 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 10 a 12 Años de Edad

Nombre del Niño: ______________________

Fecha de Nacimiento: ______________________

Fecha: ______________________

Para los Padres: *Si nos ayuda llenando este formulario, le podremos ayudar a encontrar las áreas fuertes y también cualquier área problématica que tenga su hijo. Sus respuestas nos ayudarán a saber si necesitamos hablar con usted y saber más sobre su niño. Favor de marcar todas las características abajo que son ciertas para su niño. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su niño sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

- ❑ Es inquieto
- ❑ Es triste o llora fácilmente
- ❑ Se siente culpable
- ❑ Es de mal carácter o se enoja fácilmente
- ❑ Es malhumorado
- ❑ Siente miedo
- ❑ Se aburre

COMPORTAMIENTO

¿Hace su niño cosas que le parezcan extrañas para su edad? ❑ Sí ❑ No

- ❑ Tiene problemas en la escuela
- ❑ Amenaza o lastima a otros niños o a los animales
- ❑ No le interesan las cosas que antes le gustaban
- ❑ Participa en actividades sexuales
- ❑ Destruye cosas personales o ajenas
- ❑ Roba
- ❑ Se niega a hablar
- ❑ Provoca incendios
- ❑ Es demasiado activo
- ❑ Se lastima
- ❑ Ha tenido problemas con la policía

INTERACCIONES SOCIALES

¿Se preocupa sobre cómo se lleva su niño con usted? ❑ Sí ❑ No
¿Con otros adultos? ❑ Sí ❑ No
¿Con otros niños? ❑ Sí ❑ No

- ❑ Prefiere estar solo
- ❑ Se le dificulta hacer y mantener amistades
- ❑ Es desafiante, tiene un problema de disciplina
- ❑ Siempre molesta a otros o frecuentemente se pelea (pegando, etc.)
- ❑ Discute mucho
- ❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su niño? ❑ Sí ❑ No

- ❑ Se confunde frecuentemente (no entiende lo que está pasando)
- ❑ Sueña mucho despierto
- ❑ Se distrae, no pone atención
- ❑ Tiene pensamientos muy extraños
- ❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)
- ❑ No le tiene confianza a los demás
- ❑ Mira u oye cosas que no están allí
- ❑ Culpa a otros por algo que hizo mal o por sus pensamientos
- ❑ Habla mucho sobre la muerte o del suicidio
- ❑ Frecuentemente no se acuerda de cosas

Fecha: ____________ Firma: ______________________________

Parentesco con el paciente: ______________________________

PROBLEMAS FISICOS	¿Se preocupa usted sobre los siguientes problemas físicos? ❑ Sí ❑ No Si piensa que su niño tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera debido a ese problema? ❑ Sí ❑ No
	❑ La falta energía ❑ Usa laxantes ❑ Se vomita frecuentemente ❑ No come delante de la gente, come después a escondidas ❑ Tiene dolores de estómago frecuentemente ❑ Tiene dolores de cabeza ❑ Ha perdido o aumentado mucho peso ❑ Tiene problemas para dormir, pesadillas, sonambulismo, despierta temprano, despierta seguido por la noche
OTROS	¿Es propenso a tener accidentes su niño? ❑ Sí ❑ No ¿Hay algo que le está causando tensión a su familia ahora? ❑ Sí ❑ No ¿Ha sido este niño o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional? Si sí, ¿en qué forma?__________ ¿Cuándo? ________ ❑ Sí ❑ No ¿Empezó el tratamiento? ❑ Sí ❑ No ¿Corre este niño el riesgo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento? ❑ Sí ❑ No ¿Toma bebidas alcohólicas o usa drogas su niño (incluyendo las de la calle y las que se venden sin receta)? ❑ Sí ❑ No ¿Ha recibido su niño tratamiento por problemas de la salud mental o por el abuso de sustancia como las drogas y bebidas alcohólicas? ❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

10-12YR.MH3 (9-25-96)
TDH/OLS/6-401/11-96

G

G.27 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages)

Mental Health Parent Questionnaire

Ages 13 to 20 Years

Teen's Name: ______________________

Birth Date: ______________________

Today's Date: ______________________

To the Teen or Parent: *If you will assist us by filling out this form, we can help you find your (your teen's) strengths and any problem areas, too. Your answers will help us to know if we need to talk with you (your teen) and find out more about you (your teen). Please check all items below that are true for you (your teen). Some of the behaviors noted may be normal but if you are concerned please let us know.*

Feelings	Do you (does your teen) show feelings that concern you or seem strange for your (their) age? ❑ Yes ❑ No	
	❑Restless ❑Sad or cry easily ❑Guilty ❑ Irritable or angered easily	❑ Sullen ❑ Fearful ❑ Bored

Behavior	Do you (does your teen) often do things that seem strange for your (their) age? ❑ Yes ❑ No	
	❑ Have problems in school or work ❑ Threaten or harm other children or animals ❑ Lack interest in things you used to enjoy ❑ Is involved in sexual activity ❑ Destroy possessions or other property ❑ Steal	❑ Refuse to talk ❑ Set fires ❑ Over-active ❑ Hurt yourself ❑ Have been in trouble with the police

Social Interaction	Do you have any concerns about how you (your teen) get(s) along with family members? ❑ Yes ❑ No With other adults? ❑ Yes ❑ No With peers? ❑ Yes ❑ No	
	❑ Prefer to be alone ❑ Have a hard time making and keeping friends ❑ Defiant, a disciplinary problem	❑ Pick on others a lot or often get into fights (hitting, etc.) ❑ Argue too much ❑ Will not go to school

Thinking	Are any of these a problem for you (your teen)? ❑ Yes ❑ No	
	❑ Frequently confused (does not understand what is going on) ❑ Daydream a lot ❑ Distracted, do not pay attention ❑ Have very strange thoughts ❑ Schoolwork is slipping (grades going down)	❑ Do not trust others ❑ See or hear things that are not there ❑ Blame others for your misdeeds or thoughts ❑ Talk about death or suicide a lot ❑ Often cannot remember things

Date: ___________ Signature: ______________________________

Relation to patient: ______________________________

<table>
<tr><td rowspan="2">Physical</td><td rowspan="2">Problems</td><td colspan="2">Do you have any concerns about these things? ❑ Yes ❑ No
If you think you (your teen) may have a health problem, have you (has he/she) seen a doctor or nurse about the problem? ❑ Yes ❑ No</td></tr>
<tr><td>❑ Lack energy
❑ Use laxatives
❑ Vomit (throw up) often
❑ Won't eat in front of people, sneak food later
❑ Have stomachaches often</td><td>❑ Have headaches
❑ Have lost or gained a lot of weight
❑ Have sleeping problems, nightmares, sleep-walking, early waking, frequent night waking</td></tr>
</table>

<table>
<tr><td>Other</td><td>Are you (is your teen) accident-prone? ❑ Yes ❑ No
Is anything causing your family stress right now? ❑ Yes ❑ No
Have you (has your teen) or your parents been subject to neglect, physical, sexual, or emotional abuse? If yes, what from? ____________________ When? ________ ❑ Yes ❑ No
Treatment initiated? ❑ Yes ❑ No
Are you (is this teen) at risk for out-of-home placement because of behavior problems? ❑ Yes ❑ No
Do you (does your child) drink of use drugs (including street or over-the-counter)? ❑ Yes ❑ No
Have you (has this teen) been treated for mental health problems or substance abuse? ❑ Yes ❑ No</td></tr>
</table>

Comments: *(Please write anything else you want us to know about in this space.)*

G

G.28 Mental Health Parent Questionnaire (Ages 13–20 Years) (2 Pages) (Spanish)

Cuestionario de la Salud Mental para los Padres De 13 a 20 Años de Edad

Nombre del Adolescente: ____________________

Fecha de Nacimiento: ____________________

Fecha: ____________________

Para los Padres: *Si nos ayuda llenando este formulario, podremos ayudarle a encontrar las áreas fuertes que tenga su hijo y también cualquier área problématica. Sus respuestas nos ayudarán a saber si necesitamos hablar con su hijo y saber más sobre él. Favor de marcar todas las características abajo que son ciertas para su hijo. Algunos de los comportamientos en las listas tal vez sean normales, pero si usted está preocupado, favor de informarnos.*

SENTIMIENTOS

¿Tiene su hijo sentimientos que le preocupan o tal vez parezcan extraños para su edad? ❑ Sí ❑ No

❑ Es inquieto	❑ Es malhumorado
❑ Es triste o llora fácilmente	❑ Siente miedo
❑ Se siente culpable	❑ Se aburre
❑ Es irrita o enoja fácilmente	

COMPORTAMIENTO

¿Hace su hijo cosas frecuentemente que le parezcan extrañas para su edad? ❑ Sí ❑ No

❑ Tiene problemas en la escuela o en el trabajo	❑ Se niega a hablar
❑ Amenaza o lastima a otros niños o a los animales	❑ Provoca incendios
❑ No le interesan las cosas que antes le gustaban	❑ Es demasiado activo
❑ Está envuelto en actividades sexuales	❑ Se lastima
❑ Destruye cosas personales u otras cosas ajenas	❑ Ha tenido problemas con la policía
❑ Roba	

INTERACCIONES SOCIALES

¿Le preocupa cómo se lleva su hijo con los miembros de la familia? ❑ Sí ❑ No

¿Con otros adultos? ❑ Sí ❑ No

¿Con su grupo social? ❑ Sí ❑ No

❑ Prefiere estar solo	❑ Molesta mucho a otros o frecuentemente se pelea (pegando, etc.)
❑ Se le dificulta hacer y mantener amistades	❑ Discute mucho
❑ Es desafiante, tiene un problema de disciplina	❑ No quiere asistir a la escuela

PENSAMIENTOS

¿Son algunas de estas características un problema para su hijo? ❑ Sí ❑ No

❑ Se confunde frecuentemente (no entiende lo que está pasando)	❑ No le tiene confianza a los demás
❑ Sueña mucho despierto	❑ Mira u oye cosas que no están allí
❑ Se distrae, no pone atención	❑ Culpa a otros por algo que hizo mal o por sus pensamientos
❑ Tiene pensamientos muy extraños	❑ Habla mucho sobre la muerte o el suicidio
❑ Se está atrasando en el trabajo de la escuela (sus grados están bajando)	❑ Frecuentemente no se acuerda de cosas

Fecha:____________ Firma:______________________________

Parentesco con el paciente:______________________________

13-21YR.MH4 (9-23-96)
TDH/OLS/6-402/10-96

PROBLEMAS FÍSICOS	¿Se preocupa por estas cosas?	❑ Sí ❑ No
	Si piensa que su hijo tiene un problema de salud, ¿ha ido a consultar con un médico o una enfermera por este problema?	❑ Sí ❑ No
	❑ No tiene energía	❑ Tiene dolores de cabeza
	❑ Usa laxantes	❑ Ha perdido o aumentado mucho peso
	❑ Se vomita frecuentemente	❑ Tiene problemas para dormir, pesadillas, se despierta temprano, sonámbulo y frecuentemente despierta durante la noche
	❑ No come delante de la gente, come después a escondidas	
	❑ Tiene dolores de estómago frecuentemente	
OTROS	¿Es su hijo propenso a tener accidentes?	❑ Sí ❑ No
	¿Hay algo que le está causando tensión a su familia ahora?	❑ Sí ❑ No
	¿Ha sido su hijo o sus padres sujetos a la negligencia o al abuso físico, sexual o emocional?	❑ Sí ❑ No
	Si sí, ¿en qué forma?________________ ¿Cuándo? __________	
	¿Empezó el tratamiento?	❑ Sí ❑ No
	¿Corre el riesgo su hijo de ser llevado a otro lugar fuera de su familia por problemas de comportamiento?	❑ Sí ❑ No
	¿Toma su hijo bebidas alcohólicas o drogas (incluyendo las de la calle y las que se venden sin receta)?	❑ Sí ❑ No
	¿Ha recibido su hijo tratamiento por problemas de la salud mental o por el abuso de sustancias como drogas o bebidas alcohólicas?	❑ Sí ❑ No

Comentario: *(Favor de escribir en este espacio cualquier comentario que quiera compartir con nosotros.)*

G

G.29 Hearing Checklist for Parents

Check Yes or No to Describe Your Child's Condition

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	____	____	Does your baby get quiet for a moment when you talk to him/her?
	____	____	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	____	____	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	____	____	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	____	____	Does your baby stop and pay attention when you say "no" or call his/her name?
	____	____	Does your baby move his/her head around to try to find out where a new sound is coming from?
	____	____	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	____	____	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	____	____	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	____	____	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	____	____	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?
25 to 36 months	____	____	Does your child answer different kinds of questions ("When...," "Who...," "What...")?
	____	____	Does your child notice different sounds (telephone ringing, shouting, doorbell)?
If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.			

Lista De Cotejo Para Padres

Marque si ó no para describir la condición de su hijo(a)

Age 0 to 3 Yrs	Yes	No	
0 to 3 meses	____	____	¿Se pone calladito por unos instantes cuando le platica?
	____	____	¿Parece asustárce o se para de mover por unos instantes cuando se hacen ruidos fuertes de repente?
4 to 6 meses	____	____	¿Cambia o voltea la cabeza al sonido de su voz si no puedo veria?
7 to 9 meses	____	____	¿Se detiene y pone atención cuando usted le dice que 'no' o llama su nombre?
	____	____	¿Voltea la cabeza para diferentes lados para tratar de averiguar de dónde viene el sonido cuando oye un sonido nuevo?
	____	____	¿Platica series de sonidos (como "bababa," "dadada")?
10 to 15 meses	____	____	¿Le da jugetes o otros objetos (como la mamila) cuando usted se los pide sin que usted tenga que usar un gesto (alargando la mano, o señalando)?
	____	____	¿Señala objetos familiares ("perro," "luz") si usted le pregunta?
16 to 24 meses	____	____	¿Usa su voz la mayor parte del tiempo para avisarte de lo quiere o para comunicarse con usted?
	____	____	¿Puede taer objetos familiares que son guardados en lugar habitual ("trae tus zapatos") si usted se los pide?
25 to 36 meses	____	____	¿Puede contestar diferentes tipos de preguntas ("cuándo...," "quién...," "qué")?
	____	____	¿Se fija en diferentes sonidos (teléfono, gritos, timbre de la puerta)?
Si usted tiene alguna pregunta o inquietud acerca de la audición de su hijo(a) o si usted contestó 'no' a cualquier pregunta, informese con su doctor acerca de un exámen de audición para su bebé. Los bebés pueden ser examinados de la audición desde el dia de su nacimiento.			

G.30 Guidelines: Tuberculosis Skin Testing (2 Pages)

TEXAS DEPARTMENT OF HEALTH
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Purpose:

The tuberculosis intradermal skin test is used to detect tuberculosis infection.

- To detect infection, either past or present, with Mycobacterium tuberculosis.
- To serve as a diagnostic procedure in selected patients.

Equipment:

- PPD (purified protein derivative) tuberculin antigen
- Tuberculin syringe
- Short, 3/8" 26 gauge needle
- Alcohol sponge

Procedures:

Nursing Action	Rationale/Amplification
1. Determine if patient has ever had BCG vaccine, a previously positive skin test, recent viral disease or immunization with a live virus vaccine within the last 30 days, immunosuppression by disease, drugs, or steroids.	1. A history of BCG vaccine should be documented but does not cancel the need for tuberculin skin testing.
2. Draw up 0.1 ml of PPD-tuberculin into tuberculin syringe. Each 0.1 ml should contain 5 TU (tuberculin units of PPD-tuberculin).	2. Use immediately to avoid absorption onto the plastic/glass syringe.
3. Cleanse the skin of the volar (palm side) surface of the **left** arm with alcohol. Allow to dry.	3. An intradermal test may be applied at any site but the use of the left arm is practiced universally to facilitate identifying the location of the injection site by the health care worker who reads the test. If the test is applied at another site, document the exact site of injection.
4. Stretch the skin taut.	4. Facilitates the introduction of the needle.
5. Hold the tuberculin syringe close to the skin, bevel up, so that the hub of the needle touches it as the needle is introduced.	5. Holding the syringe in this way will reduce the needle angle at the skin surface, promoting the correct entry for a proper intradermal injection.
6. Inject the tuberculin into the superficial layer of the skin to form a wheal 6mm to 10 mm in diameter.	6. If no wheal appears (because the injection was made too deep), or the wheal is smaller than 6mm (because the needle was not under the skin and part of the antigen leaked on the outer surface of the skin), reapply test at another site at least five centimeters (two inches) from the original site.

To Read the Test	Further Clarification to Reading the Test
1. Read the test within 48-72 hours.	1. Tuberculin skin tests are tests of delayed hypersensitivity. In certain circumstances, **a skin test may be read up to 96 hours after the test is applied**.
2. Have a good light available. Flex the forearm slightly at the elbow.	
3. Inspect for the presence of induration. Inspect from a side view against the light. Inspect by direct light.	3. Induration refers to hardening or thickening of the tissues.
4. Palpate: lightly rub the finger across the injection site from the area of normal skin to the area of induration. Outline the diameter of induration.	
5. Measure the maximum transverse diameter of induration (not erythema) in millimeters with a flexible ruler.	5. Erythema (redness) without induration is generally considered to be of no significance.

TEXAS DEPARTMENT OF HEALTH
GUIDELINES: TUBERCULOSIS SKIN TESTING
(PPD/MANTOUX)

Procedures

Interpretation

1. Negative reaction: An induration of 0-<5mm

1. This shows either a lack of tuberculin sensitivity or a low grade sensitivity that most likely is not caused by M. tuberculosis. A negative test does not rule out the presence of tuberculosis. Because of the possibility of a false-negative result, the tuberculin skin test should never be used to exclude the possibility of active disease among persons for whom the diagnosis is being considered.

2. Positive Reaction:
   a. An induration of 5mm or more is considered to be positive in individuals who are:
      1) contacts to a case of tuberculosis,
      2) HIV positive, or
      3) individuals with radiological findings consistent with old, healed tuberculosis.
      4) IVDU with unknown HIV status.

2a. A positive reaction indicates that a patient has had contact with tubercule bacillus. It does not necessarily mean that active disease is present in the lung, however further evaluation is required.

Individuals who are in close contact with persons with active tuberculosis and who have reactions ≥ 5 mm should be considered positive and receive preventive therapy once active disease is ruled out.

   b. An induration of 10mm or more is considered to be positive in individuals who are:
      1) at risk for tuberculosis (Foreign born individuals from countries with a high prevalence of tuberculosis),
      2) intravenous drug users known to be HIV negative,
      3) the medically under-served including high risk ethnic and racial minority populations,
      4) residents of long-term care facilities such as correctional institutions, nursing homes, or mental institutions,
      5) persons with medical conditions which have been reported to increase the risk of tuberculosis such as silicosis, being 10% under ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroids and other immunosuppressive therapy, and some hematologic disorders and malignancies,
      6) health care workers who provide services to any of the high risk groups.

2b. Individuals with skin test results of ≥10mm should be considered for preventive therapy once disease is ruled out.

Note: A tuberculin converter is a person whose tuberculin reaction increases by >10 mm in individuals <35 years of age, or increases by >15 mm in individuals >35 years of age.

   c. An induration of 15mm is considered to be positive in individuals with no risk factor for tuberculosis.

Documentation

1. Record name of antigen, strength of antigen, lot number, date of testing, and date of reading.
2. Record site of application of test if applied at site other than the left volar surface.
3. Record the size of induration.

References

1. Guidelines: Tuberculin skin test. *The Lippincott Manual of Nursing Practice*, 3rd edition, pg. 814. J. Lippincott Co. Philadelphia, Toronto.
2. Tuberculin reaction size on given consecutive days (1955) *Bulletin, World Health Organization*, 12. p. 189-196.
3. The tuberculin skin test. (1981) American Thoracic Society, medical section of American Lung Association. p. 1-8.
4. Core Curriculum on Tuberculosis (1991). Centers for Disease Control. p. 13-15.

G.31 Tuberculosis (TB) Screening and Education Tool

This screening tool for tuberculosis (TB) exposure risk is to be used annually to determine the need for tuberculin skin testing. The screening tool need not be done at visits for which tuberculin skin testing is required: ages 12-15 months and 5 years.

The questions in this screening tool are intended as a minimum screen. Follow up questions may be necessary to clarify hesitant or ambiguous responses. Questions specific to TB exposure risks in the child's community may need to be added.

- If all the answers are unqualified negatives the child is considered at low risk for exposure to TB and will not need tuberculin skin testing.
- If the answer to any question is "Yes" or "I don't know," the child should be tuberculin skin tested.
- In the case of the child for whom an answer in the past of "Yes" or "I don't know" prompted a skin test, which was negative, the skin test **may** not have to be repeated annually.
- The decision to skin test must be made by the medical provider based upon an assessment of the possibility of exposure. A negative tuberculin skin test never excludes tuberculosis infection or active disease.
- BCG vaccinated children should also have the screening tool administered annually. Previous BCG vaccination is not a contraindication to tuberculin skin testing. Positive tuberculin skin tests in BCG vaccinated children are interpreted using the same guidelines used for non-BCG vaccinated children.
- Children who have had a positive TB skin test in the past (whether treated or not), should be re-evaluated at least annually by a physician for signs and symptoms of TB.

Care of children who are newly discovered to be tuberculin skin test positive includes:

- An evaluation for signs and symptoms of TB
- A chest X-ray to rule out active disease
- Oral medications to prevent progression to active disease or multi-drug therapy if active disease is present
- Referral for consultation by a pediatric TB specialist is recommended if active disease is present
- A report to the local health authority for investigation to find the source of the infection

Feel free to photocopy the screening and education tool from this publication.

G.32 TB Questionnaire

Name of Child____Date of Birth ____________

Organization administering questionnaire______________________________ Date________

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries? ________________			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

For school/healthcare provider use only
****

PPD administered Yes___ No___
If yes,
Date administered ____/____/_____ Date read _____/_____/_____ Result of PPD test ________ mm response

Type of service provider (i.e. school, Health Steps, other clinics) ________________________

PPD provider ____________________________ ____________________________
signature printed name

Provider phone number ________________________

City ______________________________ County __________________________

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider ____

TDH Texas Department of Health FE12-11494 (5/02)

G.33 Cuestionario Para la Detección de Tuberculosis

Nombre del niño o niña ____

Organización ______________________________ Fecha ______________

La Tuberculosis (TB) es una enfermedad causada por gérmenes de TB y en la mayoriá de los casos es trasmitida por una persona adulta con tuberculosis pulmonar activa. Se transmite a otra persona por la tos y por el estornudo al expelir gérmenes de TB al aire que pueden ser respirados por los niños.

Los adultos que tienen la enfermedad activa casi siempre tienen varios de los siguientes síntomas: tos con duración de más de dos semanas, pérdida de apetito, pérdida de peso de diez libras o más en un período corto de tiempo, fiebre, escalofríos y sudores nocturnos.

Una persona puede tener gérmenes de TB en su cuerpo pero no tener la enfermedad activa. Esto se llama infección latente de TB (o LTBI por su sigla en inglés).

La TB es prevenible y curable. La prueba tuberculínica, también llamada PPD o prueba de Mantoux, se utiliza para saber si su niño o niña ha sido infectado/a con el germen de TB. No se recomienda ninguna vacuna para prevenir la tuberculosis. La prueba tuberculínica no es una vacuna contra la tuberculosis.

Necesitamos de su ayuda para saber si su niño/niña ha sido expuesto/a a la tuberculosis.

	Sí	No	No se sabe
La tuberculosis puede causar fiebre de larga duración, pérdida de peso inexplicable, tos severa (con más de dos semanas de duración), o tos con sangre. ¿Es de su conocimiento si: su niño o niña ha estado cerca de algún adulto con esos síntomas o problemas? su niño o niña ha tenido algunos de estos síntomas o problemas? su niño o niña ha estado cerca de alguna persona enferma de tuberculosis?			
¿Su niño o niña nació en México en o cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia?			
¿Su niño o niña viajó a México o a cualquier otro país de América Latina, el Caribe, Africa, Europa Oriental o Asia durante el último año por más de 3 semanas? Si su respuesta es positiva, favor de especificar a qué país o países.			
¿Es de su conocimiento, si su niño o niña pasó un tiempo (más de 3 semanas) con alguna persona que es o ha sido usuario de droga intravenosa (IV), infectado por VIH, en la prisión, o haya llegado recientemente a los Estados Unidos?			

¿A su niño o niña se le ha realizado la prueba tuberculínica recientemente? Sí___ (si sí, especifique la fecha ____/____) No___
¿Su niño o niña alguna vez tuvo reacción positiva a la tuberculina? Sí___ (si sí, especifique la fecha ____/____) No___

Solamente para uso de la escuela o del proveedor de servicios médicos
****

¿Se administró PPD? Sí___ No___
Si sí,
Fecha en que fue administrada_____/_____/_____ Fecha de lectura _____/_____/_____ Resultado de la prueba_____ mm

Tipo de proveedor de servicio (ej.: escuela, Health Steps, otras clínicas) ______________________________

Administrador de PPD ______________________________ ______________________________
firma nombre en letra de molde (imprenta)

Número de teléfono del administrador de PPD ______________________________

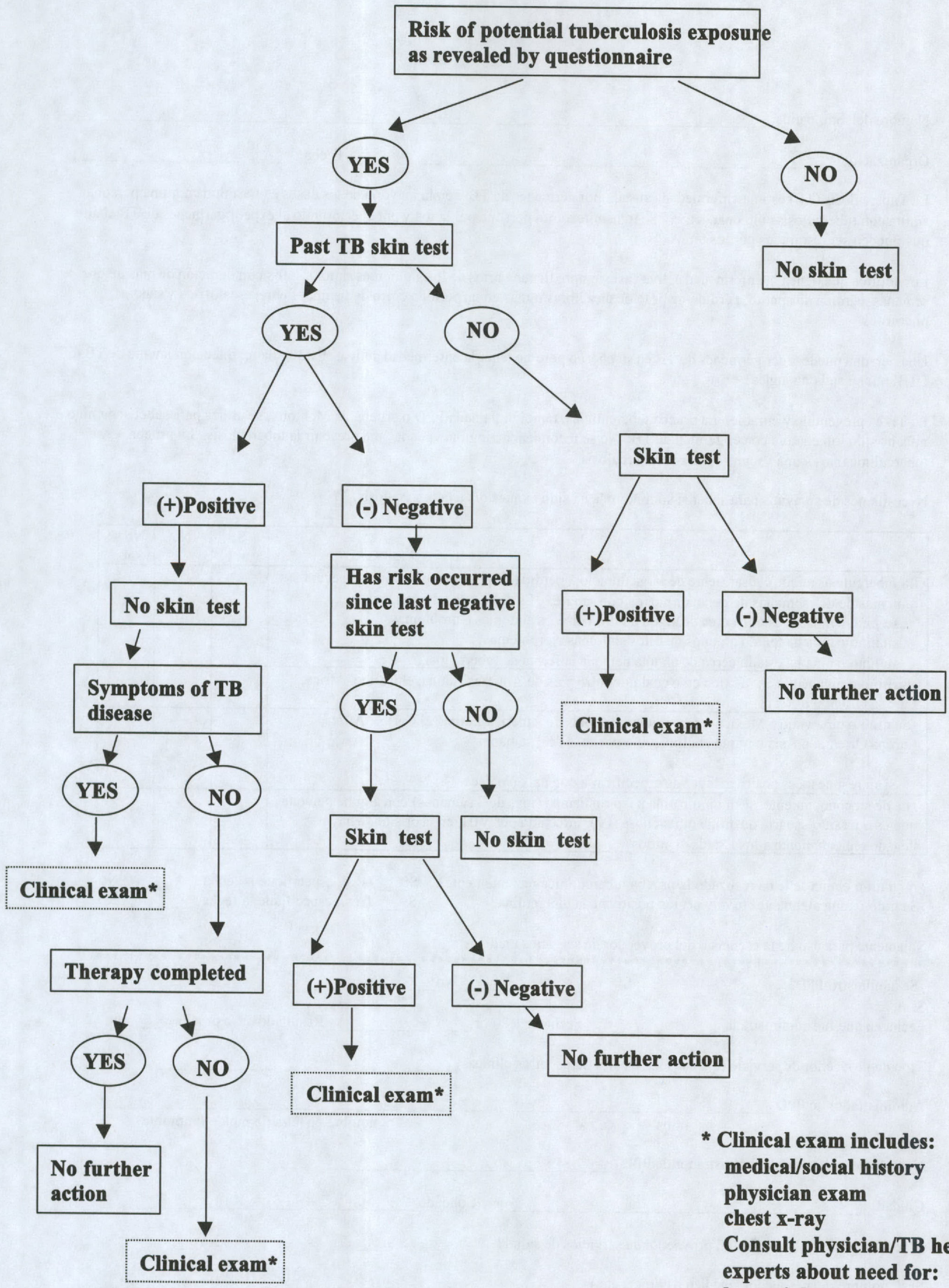
Ciudad______________________________ Condado______________________________

Si resultó positivo, ¿se refirió al proveedor de servicios de salud? Sí___ No___

Si sí, nombre del proveedor (médico o clínica, etc.) ______________________________

Texas Department of Health FE12-11494A (5/02)

G.34 How to Determine TB Risk



G.35 Screening Schedule for High-Blood Leads

Age of child	May use primary parent questionnaire	May use abbreviated parent questionnaire	Blood lead test required	Conditions
6 mths.	yes			
12 mths.			yes	
18 mths.	yes			
24 mths.			yes	
3, 4, 5, and 6 years	yes, if any answer on abbreviated parent questionnaire is "yes"	yes		if child has no record of a blood lead test, child MUST have an actual blood lead test

Note: A "yes" or "I don't know" answer to any question on any parent questionnaire indicates that a blood lead test should be administered.

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G.36 THSteps Primary Parent Risk Assessment for Lead Exposure Questionnaire

Patient's Name: ____________________________

Date Questionnaire Administered: ____________________

Texas Health Steps

PRIMARY PARENT QUESTIONNAIRE

SCREENING QUESTIONS FOR A CHILD WHO HAS NEVER HAD A HIGH BLOOD LEAD

This questionnaire is about lead. Lead is a dangerous substance that sometimes gets into children's bodies. It can make them sick and affect their behavior and ability to learn. Answers to these questions will help the doctor see if your child may have been exposed to lead. If your child has been exposed to lead, the doctor will need to do a blood test. The test may show that the child has lead in his/her blood or it may show that your child is fine. Even if your child does have a high blood lead, the doctor can tell you things that you can do to help your child be healthy. If any of these questions are confusing, ask the doctor or nurse to help you with them.

1) Do you live in or often visit a house that was probably built before 1978?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

2) Does your child live in or often visit a house that is being painted, remodeled, or having the paint scraped or sanded?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

3) Does your child eat or chew on non-food things like paint chips or dirt?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

4) Have any other members of the family or your child's playmates had high blood leads as far as you know?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

5) Does you family live near or does your child play near any of these (circle the ones that apply):

smelter
hazardous waste site
lead industry
place where batteries are manufactured or repaired
house construction site
heavily traveled major highway
place where cars are abandoned or repaired?

6) Do you give your child, or have you ever given your child, any of these products from another country:

MEDICINES like greta or azarcon for empacho, alarcon, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, or rueda?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

NUTRITIONAL PILLS OTHER THAN VITAMINS?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

7) Does anyone living in your house work at a place where any of these things happen or have a hobby that involves these things? (circle the ones that apply):

radiator repair
lead industry
welding
battery manufacture or repair
house construction or repair
smelting
chemical preparation
making pottery
going to a firing range
stained glass with lead solder
brass/copper foundry
valve and pip fittings
bridge, tunnel and elevated highway construction
industrial machinery and equipment
reloading bullets or making fishing weights
refinishing furniture
burning lead-painted wood
automotive repair shop

Does anybody that your child spends a lot of time with (outside of your home) do any of these things or work at a place where these things are done?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

8) Is imported or glazed pottery, or a Mexican bean pot, used to cook or store your food?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

9) Does your child eat foods canned or packaged (such as candy) outside the U.S.?

❑ **YES** ❑ **NO** ❑ **I DON'T KNOW**

G.37 THSteps Primary Parent Risk Assessment for Lead Exposure Questionnaire (2 Pages) (Spanish)

Nombre del paciente:______________________________

Fecha de Administración del Cuestionario:____________________

Pasos para la Salud en Texas

CUESTIONARIO PRIMARIO PARA LOS PADRES

PREGUNTAS DE DETECCIÓN PARA NIÑOS QUE NUNCA HAN TENIDO ALTOS NIVELES DE PLOMO EN LA SANGRE

Este cuestionario es sobre el plomo. El plomo es una substancia dañina que algunas veces se introduce en el cuerpo de los niños. Puede enfermarlos y afectar su comportamiento, asĺ como su capacidad de aprendizaje. Las respuestas a estas preguntas ayundarán al médico a saber si su hijo(a) puede haber estado expuesto al plomo. Si su hijo(a) ha estado expuesto al plomo, el médico necesitara hacerle una prueba de sangre. La prueba puede mostrar si su hijo(a) tiene plomo en la sangre o puede indicar que su hijo(a) esta bien. Aun si su hijo(a) tien altos niveles de plomo en la sangre, el médico puede darle indicaciones sobre lo que puede hacer para ayudar a su hijo(a) a estar sano. Si algunas de las preguntas son confusas, preguntele al médico o a la enfermera que le ayuden.

1) ¿Vive usted en o visita frecuentemente alguna casa que probablemente haya sido construida antes de 1978?

Sĺ ❏ NO ❏ NO LO SE ❏

2) ¿Vive su hijo(a) en o visita frecuentemente una casa que está siendo pintada, remodelada, o que están pelando o lijando la pintura?

Sĺ ❏ NO ❏ NO LO SE ❏

3) ¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura u objetos sucios?

Sĺ o NO ❏ NO LO SE ❏

4) ¿Algún otro miembro de la familia o compañeritos de juego tienen altos niveles de plomo en la sangre, que usted esté enterada?

Sĺ ❏ NO ❏ NO LO SE ❏

5) ¿Su familia vive cerca o su hijo(a) juega cerca de alguno de los siguientes lugares? (encierre en un círculo la respuesta)

fundición
sitio de desperdicios peligrosos
industria de plomo
lugar donde se fabrican o reparan baterías
sitio de construcción de una casa
autopista con mucho tránsito
lugar donde los autos son reparados o abandonados

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6) ¿Le da usted o le ha dado alguna vez a su hijo(a) alguno de los siguientes productos provenientes de otro páis?

- MEDICINAS tales como greta, o azarcon para el empacho, alarcon, alkohl, bali goli, coral ghasard, liga, pay-loo-ah, o rueda?

SI ❑ NO ❑ NO LO SE ❑

- PÍLDORAS NUTRICIONALES QUE NO SEAN VITAMINAS

SI ❑ NO ❑ NO LO SE ❑

7) ¿Hay alguna persona viviendo en su casa que trabaje en un lugar donde se realice alguna de las cosas ques cribimos a continuacion o que tengan un pasatiempo que involucre alguna de los siguientes? (encierre en un **círculo** la respuesta):

reparación de radiador
industria del plomo
soldadura
fabricación y reparación de baterías
construcción o reparación de casas
fundición (de metales)
preparación de químicos
fabricación de bitrales con soldadura de plomo
fundición de latón/cobre
partes sueltas para tubos de cañerias y válvulas
construcción de una autopista elevada, puente, túnel
equipo y maquinaria industrial
recargo de balas de armas de fuego o fabricación de pesas para pescar
terminado de muebles
quema de madera pintada con plomo
taller mecánico para autos

¿Alguna persona con quien su hijo pasa largo tiempo, hace alguna de las siguientes cosas o trabaja en lugares (fuera de la casa) donde se realizan las actividades antes mencionadas?

SÍ ❑ NO ❑ NO LO SE ❑

8) ¿Usa usted productos de ceramica importada o con recubrimiento de barniz, o una olla para frijoles de México, para cocinar o para guardar su comida?

SÍ ❑ NO ❑ NO LO SE ❑

9) ¿Come su hijo(a) productos enlatados o empacados (tales como dulces) fuera de los Estados Unidos?

SÍ ❑ NO ❑ NO LO SE ❑

02/97

G.38 Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure

Patient's Name: ________________________________

Date Questionnaire Administered: ______________________

ABBREVIATED PARENT QUESTIONNAIRE
RISK ASSESSMENT FOR LEAD EXPOSURE

You may use the Abbreviated Parent Questionnaire for lead screening:

1. At the patient's 3, 4, 5, and 6 year visits.
2. If the patient has never had an elevated blood lead level.
3. If the parent answered "no" to all questions on the primary lead screening parent questionnaire at the 6-month and 18-month visits.

If the parent answers "yes" to any of the questions below, you must administer the Primary Parent Questionnaire or give the child a blood lead test.

1. Has your residence changed since your child's last lead screen?
   YES ❑ NO ❑

2. Has your child changed babysitters or daycare centers since the last lead screen?
   YES ❑ NO ❑

3. Has anyone in your home changed jobs since your child's last lead screen?
   YES ❑ NO ❑

4. Has anyone in your home been:
   - reloading bullets
   - making pottery
   - making stained glass
   - refinishing furniture
   - working on autos
   - going to a firing range

5. Since the last lead screen, has your child been around any home remodeling or houses that are having the paint removed?
   YES ❑ NO ❑

6. Are you giving your child medications produced outside the United States, like Greta or Azarcon?
   YES ❑ NO ❑

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G.39 Abbreviated Parent Questionnaire: Risk Assessment for Lead Exposure (Spanish)

Nombre del paciente:____

Fecha de Administración del Cuestionario:______________________________

CUESTIONARIO ABREVIADO PARA LOS PADRES
EVALUACIÓN DE RIESGO POR EXPOSICIÓN AL PLOMO

Usted puede usar el Cuestionario Abreviado para los Padres para la detección de Plomo en la sangre:

1. En las visitas anuales 3, 4, 5, y 6 del paciente.
2. Si el paciente nunca ha tenido un elevado nivel de plomo en la sangre.
3. Si los padres contestaron "no" a todas las preguntas del cuestionario para los padres para la detección primaria de plomo durante las visitas de los 6 y 18 meses.

Si los padres contestan "si" a cualquiera de las preguntas que siguen, usted debe administrar el Cuestionario Primario para Padres o hacerle al niño un examen para la detección de plomo en la sangre.

1. ¿Se ha cambiado de domicilio desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ NO ❑

2. ¿Ha cambiado a su hijo(a) de niñera o de guardería desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ NO ❑

3. ¿Alguna de las personas que viven en su casa ha cambiado de trabajo desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre?

   SÍ ❑ NO ❑

   Si contestó sí, escriba el nombre del nuevo trabajo:______________________________

4. Alguna persona en su casa ha estado:
   - recargando balas en armas
   - trabajando con cerámica
   - trabajando con vitrales
   - terminado de muebles
   - trabajando en automóviles
   - yendo a un campo de tiro

   SÍ ❑ NO ❑

5. ¿Desde que su hijo(a) tuvo el último examen para la detección de plomo en la sangre ha estado él en cualquier casa que se esté remodelando o casas donde estén quitando la pintura?

   SÍ ❑ NO ❑

   ¿Le está dando a su hijo(a) alguna medicación producida fuera de los Estados Unidos, tales como Greta o Azarcón?

   SÍ ❑ NO ❑

02/97

G.40 San Antonio State Chest Hospital Cervical Cancer Cytology Laboratory

ID Card

Last Name (PLEASE PRINT LEGIBLY)
First Name MI
Street Address

City Zip code
Patient I.D. No.____________________
S.S.N. ________ - ________ - ________
Date of Birth _____/_____/_____ Age ___
Medicaid / Medicare Number
Clinic Code:____________________
Clinic Type Mty FP AH CD EPSDT
Clinic Name and Address: New Address? ❑

Mail report to: (if different from above)

FOR CLINIC USE ONLY
Tests (circle) Cytology Gonorrhea/Chlamydia
(required specimen) (glass slide) (special swab in transparent medium)
Source of Cytology Specimen: Cervix Vagina
Other:
Cytobrush:Yes No Cervical Biopsy: Yes No

Date of Smear ____/____/____ Date of LMP ____/____/____
DATE

CLINICAL HISTORY: Post Menopausal Yes No
Pregnant Yes No Post Partum Yes No
I.U.D. Yes No Hormones Yes No
Cryotherapy Yes No Laser Yes No
Hysterectomy Yes No Radiation Yes No
Prior Abnormal Yes No Dx and Lab No. ____________

Race: W H B AI AS Other:
History of physical findings: ____________________

I, ____________________, authorize the S.A.S.C.H. to release to ____________________ any cytologic or biologic reports, slides, and/or blocks at their request.

I further assign all benefits payable under my insurance coverage through ____________________ to the TDH for these services.

Patient signature Policy number Date
Witness signature Printed name Date
Signature of policy holder Printed name Date
(If different from patient)

REQUIRED INFORMATION

Laboratory for Women's and Children's Health
SAN ANTONIO STATE CHEST HOSPITAL
CERVICAL CYTOLOGY CANCER LABORATORY
2303 S.E. Military Drive
San Antonio TX 78223
(210) 534-8857 x361
FAX (210) 534-8857
TxAn 827-8361
FAX 827-8266

FOR LAB USE ONLY
Accession Number:
Condition on Receipt:❑ Adequate❑ Broken in Transit____% Less
❑OTHER:

Tech:____________Q.C. Tech____________Pathologist ____________

STATEMENT OF SPECIMEN ADEQUACY

Satisfactory ❑❑❑ **Limited by** ❑❑❑ **Unsat** ❑❑❑
A ❑❑❑ Yes ECs B ❑❑❑ Scant Cell E ❑❑❑ Blood
G ❑❑❑ No ECs C ❑❑❑ Poor fix F ❑❑❑ Cytol
❑❑❑ NA ECs D ❑❑❑ Inflare H ❑❑❑ Thick

BENIGN CELLULAR CHANGES

1 ❑❑❑ WBCs 5 ❑❑❑ Yeast 9 ❑❑❑ R & R
2 ❑❑❑ Inf Chng 6 ❑❑❑ S. Flora 10 ❑❑❑ Atrophy
3 ❑❑❑ Bacteria 7 ❑❑❑ Herpes 11 ❑❑❑ Radiation
4 ❑❑❑ Trich 8 ❑❑❑ Actino 12 ❑❑❑ EC vaginal
Comment:

EPITHELIAL ABNORMALITIES

1 ❑❑❑ Atypical Squamous Cells J ❑❑❑ Probably reactive
K ❑❑❑ s/o Low Grade SIL
2 ❑❑❑ Low Grade SIL A ❑❑❑ HPV changes
B ❑❑❑ Mild dysplaysia
3 ❑❑❑ High Grade SIL C ❑❑❑ Moderate dysplasia
D ❑❑❑ Severe dysplasia/CIS
4 ❑❑❑ Atypical Glandular Cells
e ❑❑❑ Endometrial 5 ❑❑❑ EMs out of phase
f ❑❑❑ Endocervical 6 ❑❑❑ EMs in PMP patient
g ❑❑❑ Not specified 7 ❑❑❑ EMs w/o history
Comment:

RECOMMENDATIONS

1 ❑Repeat smear 4 ❑Repeat 6 months 7 ❑E.C.C.
2 ❑Repeat p therapy 5 ❑Colposcopy 8 ❑Repeat mid-cycle
3 ❑Repeat 3 months 6 ❑Biopsy 9 ❑Repeat p estrogen
Tech/Date ____________________
Q.C./Date ____________________ Pathologist ____________

G.41 Specimen Submission Form G-1A

Texas Department of Health
Bureau of Laboratories
1100 W. 49th Street
Austin, Texas 78756-3194
TDH
512-458-7318 CLIA #45D0660644
http://www.tdh.state.tx.us/lab/

Specimen Submission Form G-1A (September 2002)
Specimen Acquisition: (512) 458-7598

Section 1. SUBMITTER INFORMATION

Submitter number | Submitter name
Address
City | State TX | Zip
Phone | Contact
Fax | Clinic code

Section 2. PATIENT INFORMATION – (Fields REQUIRED for Medicare & Medicaid)**

Note: Patient name on specimen is REQUIRED and MUST match name on form.

Date of collection** | Previous TDH specimen no.
Last name** | First name** | MI
Address**
City** | State** | Zip**
DOB(mm/dd/yy) ** | Age | Sex** | SSN** | Pregnant ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Patient ID number | ICD Diagnosis code** | Country of origin
Date of onset | Diagnosis/Symptoms | Risk

☐ Inpatient ☐ Outpatient ☐ Outbreak association: ☐ Surveillance

Section 3. PHYSICIAN INFORMATION **REQUIRED for Medicare

Physician's name**
Physician's UPIN**

Section 4. PAYOR SOURCE REQUIRED

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or other. If Medicaid or Medicare is selected, the Medicaid/Medicare number is required. If private insurance or other is selected, the required billing information below is indicated with an (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED**

☐ Submitter ☐ Private insurance
☐ Medicaid ☐ Other
☐ Medicare

Medicaid/Medicare #: ____________

TDH Programs
☐ THSteps
☐ HIV/STD
☐ Immunizations
☐ Infect. Disease Epi. & Surveillance
☐ Primary Health Care
☐ Refugee
☐ Tuberculosis

☐ Service Delivery Integration
Title V
☐ Family Planning
☐ MCH (Maternal Child Health)
☐ Title X – Family Planning
☐ Title XX – Family Planning
☐ Zoonosis
☐ Other:

HMO/Managed care/Insurance company name*
Address*
City* | State* | Zip*
Responsible party*
Insurance phone no.* | Responsible party's insurance ID no.*
Group name* | Group no.*

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of Health, Bureau of Laboratories."
Signature of patient or responsible party.

Signature* Date*

Section 5. SPECIMEN SOURCE OR TYPE

☐ Abscess (site) ________
☐ Blood
☐ Blood: Filter paper
☐ Bone marrow
☐ Bronchial washings
☐ Cervical
☐ CSF
☐ Eye
☐ Feces/stool
☐ Gastric
☐ Lesion (site)________
☐ Lymph node (site)________
☐ Nasopharyngeal
☐ Plasma
☐ Rectal swab
☐ Serum
Acute date: ___/___/___
Conval. date: ___/___/___
☐ Sputum: Induced
☐ Sputum: Natural
☐ Throat
☐ Tissue (site) ________
☐ Urethral
☐ Urine
☐ Vaginal
☐ Wound (site) ________
☐ Other:

REFERENCE SEROLOGY/IMMUNOLOGY

☐ Arbovirus panel @
☐ Aspergillosis
☐ Brucellosis c @
☐ Cat-scratch fever (Bartonella) c @
☐ Cytomegalovirus ☐ IgGc ☐ IgM
☐ Ehrlichia
☐ Fungal panel/ID
☐ Hantavirus c @
☐ Hepatitis A total
☐ Hepatitis A IgM
☐ Hepatitis B surface Ab
☐ Hepatitis B surface Ag
☐ Hepatitis B core
☐ Hepatitis Be Ag
☐ Hepatitis Be Ab
☐ Hepatitis C
☐ Influenza A/B
☐ Legionellosis c
☐ Lyme disease c @
☐ Mumps ☐ IgGc ☐ IgM @
☐ Plague c @
☐ Polio c
☐ Q fever
☐ Rickettsial panel
☐ Rubella ☐ IgGc ☐ IgM @
☐ Rubeola ☐ IgGc ☐ IgM @
☐ Toxoplasma ☐ IgG ☐ IgM
☐ Tularemia c @
☐ Varicella Zoster IgG c
☐ Other:

CDC Reference Tests: @

☐ Chagas disease
☐ Cystercercosis
☐ Echinococcus
☐ HIV-2
☐ HTLV-I
☐ Leptospirosis
☐ Toxocariasis
☐ Other:

MCH SCREENNG

☐ Rubella, Syphilis, Hep BS Ag, HIV
☐ Rubella, Syphilis, Hep BS Ag
☐ HIV only
☐ Rubella only (Title V – Family Planning)

SYPHILIS SEROLOGY

☐ RPR - Syphilis screen
☐ RPR – Test of cure
☐ TP-PA (confirmation)
☐ FTA - ABS
☐ VDRL (CSF only)

HIV/HCV SCREENING

☐ HIV/HCV
☐ HIV only
☐ HCV only
☐ EIA
☐ Western blot

MYCOBACTERIOLOGY/MYCOLOGY

Clinical specimens:
☐ AFB smear & culture
☐ AFB smear, culture, & fungal culture

Pure cultures:
☐ AFB ID
☐ Fungus ID
☐ Other aerobic actinomycetes ID
☐ MTB 1st drug panel
☐ MTB 2nd drug panel
☐ MTB PZA
☐ Other:

VIROLOGY

☐ Chlamydia isolation
☐ EM
☐ Influenza surveillance
☐ Virus isolation
☐ Virus ID
Suspected:
Submitted on:
☐ Other:

ENTOMOLOGY

For Isolation:
☐ Lyme disease @
☐ Rocky Mountain spotted fever @
☐ Relapsing fever @
☐ Insect ID
☐ Other:

PARASITOLOGY

☐ Intestinal parasites @
☐ Pinworm swab
☐ Blood/Tissue parasites @
☐ Worm ID
☐ Fixative:
☐ Stain:
☐ Other:

BACTERIOLOGY

Clinical specimens:
☐ Aerobe isolation
☐ Amplified probe
☐ Anaerobe isolation
☐ Botulism
☐ Diphtheria screen
☐ Enteric pathogens
☐ Gonorrhea/Chlamydia (genetic probe)
☐ Gonorrhea culture
☐ Pertussis culture
☐ Pertussis/slide only
☐ Strep screen
☐ Toxin/ EHEC
☐ Toxin/ Other

Pure cultures:
☐ Aerobe ID only
☐ Anaerobe ID only
☐ Campylobacter ID only

Special studies:
☐ Toxin studies
☐ Other:

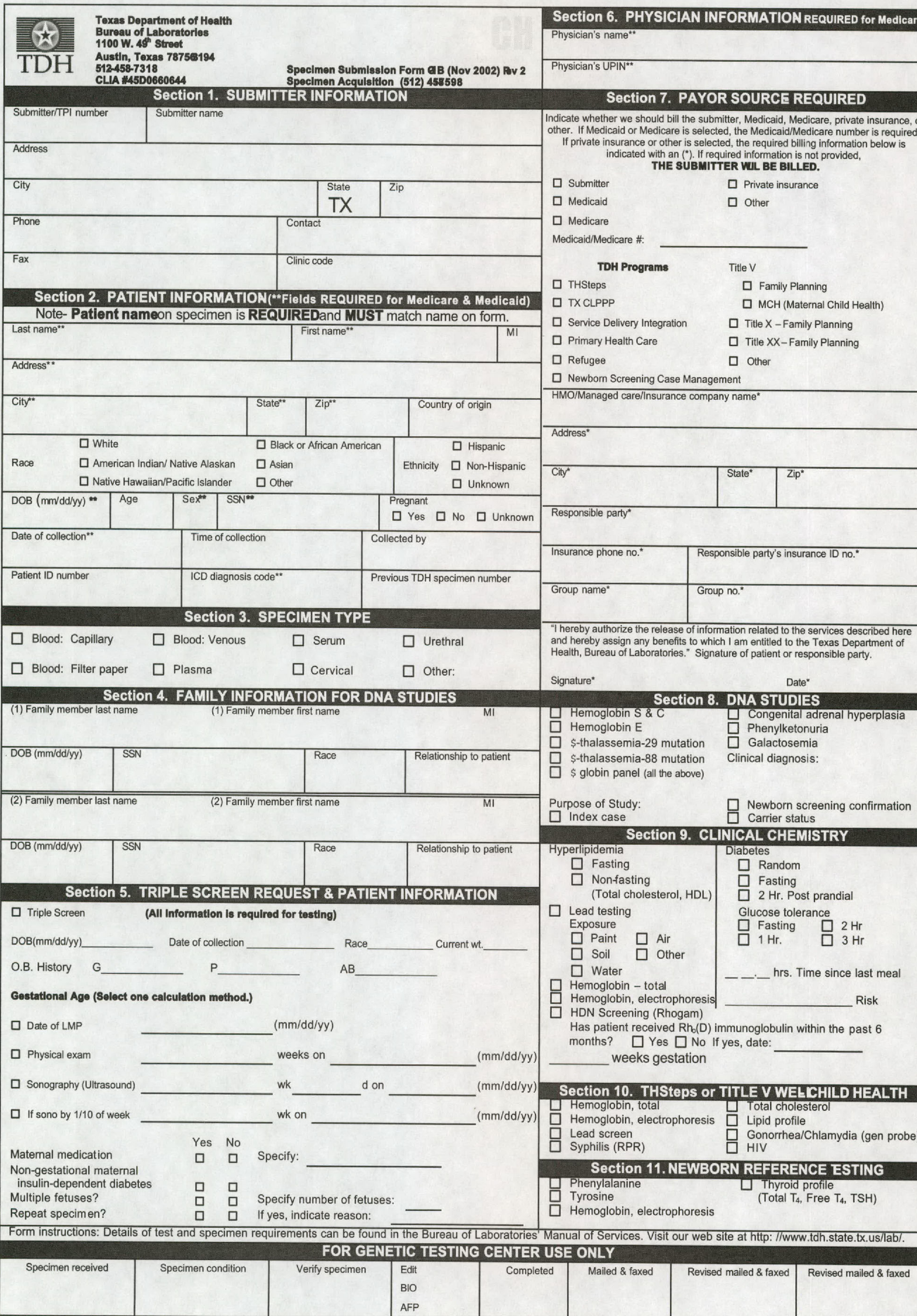
ID and typing:
☐ Haemophilus influenzae
☐ Neisseria meningitidis
☐ E. coli (EHEC only)
☐ Salmonella
☐ Shigella
☐ Streptococcus, GAS
☐ Other:

Molecular studies:
☐ PFGE for:
☐ PCR for:
☐ Other:

Form Instructions: c Requires acute and convalescent specimens. @ = Provide patient history on reverse side of form to avoid delay of specimen processing. For pure culture ID please provide biochemical reactions on reverse side of form or attach copy of biochemistry printout. Each test block (ex. Reference Serology/Immunology) requires a separate form and specimen. Details of test and specimen requirements can be found in the Bureau of Laboratories' Manual of Services. Visit our web site at http://www.tdh.state.tx.us/lab/.

For TDH use only; Specimen Rec'd: ☐ Room temp ☐ Cold ☐ Frozen

G.42 Specimen Submission Form G-1B



Texas Department of Health
Bureau of Laboratories
1100 W. 49th Street
Austin, Texas 78756-3194
512-458-7318
CLIA #45D0660644

TDH

Specimen Submission Form G-1B (Nov 2002) Rev 2
Specimen Acquisition (512) 458-7598

Section 1. SUBMITTER INFORMATION

Submitter/TPI number | Submitter name
Address
City | State TX | Zip
Phone | Contact
Fax | Clinic code

Section 2. PATIENT INFORMATION (Fields REQUIRED for Medicare & Medicaid)**

Note- **Patient name** on specimen is **REQUIRED** and **MUST** match name on form.

Last name** | First name** | MI
Address**
City** | State** | Zip** | Country of origin
Race: ☐ White ☐ American Indian/ Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Black or African American ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
DOB (mm/dd/yy) ** | Age | Sex** | SSN** | Pregnant ☐ Yes ☐ No ☐ Unknown
Date of collection** | Time of collection | Collected by
Patient ID number | ICD diagnosis code** | Previous TDH specimen number

Section 3. SPECIMEN TYPE

☐ Blood: Capillary ☐ Blood: Venous ☐ Serum ☐ Urethral
☐ Blood: Filter paper ☐ Plasma ☐ Cervical ☐ Other:

Section 4. FAMILY INFORMATION FOR DNA STUDIES

(1) Family member last name | (1) Family member first name | MI
DOB (mm/dd/yy) | SSN | Race | Relationship to patient
(2) Family member last name | (2) Family member first name | MI
DOB (mm/dd/yy) | SSN | Race | Relationship to patient

Section 5. TRIPLE SCREEN REQUEST & PATIENT INFORMATION

☐ Triple Screen **(All information is required for testing)**

DOB(mm/dd/yy)______ Date of collection______ Race______ Current wt.______

O.B. History G______ P______ AB______

Gestational Age (Select one calculation method.)

☐ Date of LMP ______ (mm/dd/yy)
☐ Physical exam ______ weeks on ______ (mm/dd/yy)
☐ Sonography (Ultrasound) ______ wk ______ d on ______ (mm/dd/yy)
☐ If sono by 1/10 of week ______ wk on ______ (mm/dd/yy)

	Yes	No	
Maternal medication	☐	☐	Specify:
Non-gestational maternal insulin-dependent diabetes	☐	☐	
Multiple fetuses?	☐	☐	Specify number of fetuses:
Repeat specimen?	☐	☐	If yes, indicate reason:

Section 6. PHYSICIAN INFORMATION REQUIRED for Medicar

Physician's name**
Physician's UPIN**

Section 7. PAYOR SOURCE REQUIRED

Indicate whether we should bill the submitter, Medicaid, Medicare, private insurance, or other. If Medicaid or Medicare is selected, the Medicaid/Medicare number is required. If private insurance or other is selected, the required billing information below is indicated with an (*). If required information is not provided, **THE SUBMITTER WILL BE BILLED.**

☐ Submitter ☐ Private insurance
☐ Medicaid ☐ Other
☐ Medicare
Medicaid/Medicare #: ______

TDH Programs: ☐ THSteps ☐ TX CLPPP ☐ Service Delivery Integration ☐ Primary Health Care ☐ Refugee ☐ Newborn Screening Case Management

Title V: ☐ Family Planning ☐ MCH (Maternal Child Health) ☐ Title X – Family Planning ☐ Title XX – Family Planning ☐ Other

HMO/Managed care/Insurance company name*
Address*
City* | State* | Zip*
Responsible party*
Insurance phone no.* | Responsible party's insurance ID no.*
Group name* | Group no.*

"I hereby authorize the release of information related to the services described here and hereby assign any benefits to which I am entitled to the Texas Department of Health, Bureau of Laboratories." Signature of patient or responsible party.

Signature* | Date*

Section 8. DNA STUDIES

☐ Hemoglobin S & C
☐ Hemoglobin E
☐ $-thalassemia-29 mutation
☐ $-thalassemia-88 mutation
☐ $ globin panel (all the above)
☐ Congenital adrenal hyperplasia
☐ Phenylketonuria
☐ Galactosemia
Clinical diagnosis:

Purpose of Study: ☐ Index case ☐ Newborn screening confirmation ☐ Carrier status

Section 9. CLINICAL CHEMISTRY

Hyperlipidemia
☐ Fasting
☐ Non-fasting (Total cholesterol, HDL)
☐ Lead testing
Exposure ☐ Paint ☐ Air ☐ Soil ☐ Other ☐ Water
☐ Hemoglobin – total
☐ Hemoglobin, electrophoresis
☐ HDN Screening (Rhogam)
Has patient received Rh_o(D) immunoglobulin within the past 6 months? ☐ Yes ☐ No If yes, date: ______
______ weeks gestation

Diabetes
☐ Random
☐ Fasting
☐ 2 Hr. Post prandial
Glucose tolerance
☐ Fasting ☐ 2 Hr
☐ 1 Hr. ☐ 3 Hr
__ __.__ hrs. Time since last meal
______ Risk

Section 10. THSteps or TITLE V WELL CHILD HEALTH

☐ Hemoglobin, total
☐ Hemoglobin, electrophoresis
☐ Lead screen
☐ Syphilis (RPR)
☐ Total cholesterol
☐ Lipid profile
☐ Gonorrhea/Chlamydia (gen probe)
☐ HIV

Section 11. NEWBORN REFERENCE TESTING

☐ Phenylalanine
☐ Tyrosine
☐ Hemoglobin, electrophoresis
☐ Thyroid profile (Total T_4, Free T_4, TSH)

Form instructions: Details of test and specimen requirements can be found in the Bureau of Laboratories' Manual of Services. Visit our web site at http: //www.tdh.state.tx.us/lab/.

FOR GENETIC TESTING CENTER USE ONLY

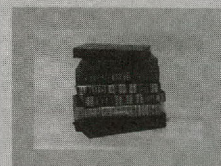
Specimen received	Specimen condition	Verify specimen	Edit BIO AFP	Completed	Mailed & faxed	Revised mailed & faxed	Revised mailed & faxed

G

Appendix

THSteps Quick Reference Guide

H.1 Texas Health Steps Quick Reference Guide 174



H.1 Texas Health Steps Quick Reference Guide

TEXAS HEALTH STEPS QUICK REFERENCE GUIDE

Remember Required Claim Components:

- Use THSteps Medical TPI
- Use Diagnosis Code V202
- Use one Examination Procedure Code
- Use one Performing Provider Modifier
- Use Appropriate Condition Indicator
- Indicate immunizations and/or TB Skin Test codes as appropriate

THSteps Medical Checkup Billing Codes

THSTEPS MEDICAL CHECK-UPS

Preventative medicine services

Code	Description
99381	New Patient, infant (age under 1 year)
99382	New Patient, early childhood (age 1 through 4 years)
99383	New Patient, late childhood (age 5 through 11 years)
99384	New Patient, adolescent (age 12 through 17 years)
99385	New Patient, (age 18 through 20 years)
99391	Established Patient, infant (age under 1 year_
99392	Established Patient, early childhood (age 1 through 4 years)
99393	Established Patient, late childhood (age 5 through 11 years)
99394	Established Patient, adolescent (age 12 through 17 years)
99395	Established Patient, (age 18 through 20 years)

THSTEPS FOLLOW-UP VISIT

Code	Description
99211	THSteps Follow Up Visit

EXCEPTION TO PERIODICITY THSTEPS MEDICAL CHECK-UPS

(Use Modifiers 23, 32, or SC to indicate the reason for an exception to periodicity)

Code	Description
99381	New Patient, infant (age under 1 year)
99382	New Patient, early childhood (age 1 through 4 years)
99383	New Patient, late childhood (age 5 through 11 years)
99384	New Patient, adolescent (age 12 through 17 years)
99385	New Patient, (age 18 through 20 years)
99391	Established Patient, infant (age under 1 year_
99392	Established Patient, early childhood (age 1 through 4 years)
99393	Established Patient, late childhood (age 5 through 11 years)
99394	Established Patient, adolescent (age 12 through 17 years)
99395	Established Patient, (age 18 through 20 years)

Exception to Periodicity Modifiers

(Use with medical screen codes 99381-99385 or 99391-99395 to indicate the reason for an exception to periodicity)

Modifier	Description
23	Unusual Anesthesia
32	Mandated Services
SC	Medically Necessary Services

CONDITION INDICATOR CODES

Use to indicate a referral was made or was not made.

Condition Indicator	Condition Indicator Codes	Description
N	NU	Not used (no referral)
Y	ST	New services requested
Y	S2	Under treatment

TB SKIN TEST

Be sure to include a charge, at least $.01 even though this code is not reimbursed separately.

Code	Description
86580	Skin test; tuberculosis, intradermal

IMMUNIZATIONS ADMINISTERED

- Each administration code must have a corresponding vaccine code.
- If only one immunization is administered during a checkup, providers should bill procedure code 90471/90473 with a quantity of 1.
- If two or more immunizations are administered, providers should bill procedure code 90471/ 90473 with a quantity of 1, procedure code 90472/90474 with a quantity of 1 or more (depending on the number of vaccines administered), and the appropriate national vaccine codes that describe each immunization administered. Texas Medicaid considers vaccine codes informational.

Administration Codes

Must be accompanied by an Informational Vaccine Code(s) found below.

Code	Description
90471	Injections
90472	Injections
90473	Intranasal/Oral
90474	Intranasal/Oral

Informational Vaccine Codes

Be sure to include a charge, at least $.01 even though these codes are not reimbursed separately.

Code	Vaccine
90700	DTaP
90702	DT
90718	TD
90720	DTP/Hib
90701	DTP
90632 or 90633	HEP A
90744 or 90746	HEP B
90645 or 90646 or 90647 or 90648	HibCV
90713	IPV
90712 (oral)	OPV
90707	MMR
90716	Varicella
90669	PCV-7 (Prevnar)

MODIFIERS

Performing Provider

Use to indicate the practitioner who performed the unclothed physical examination on the medical screen. Required with exam codes and follow-up code.

Modifier	Description
AM	Physician, team member service
SA	Nurse Practitioner rendering service in collaboration with a physician
TD	RN
U7	Physician's Assistant services for other that assistant at surgery

FQHC

FQHC providers must use this modifier for THSteps services in conjunction with one of the performing provider modifiers listed above.

Modifier	Description
EP	Service provided as part of Medicaid EPSDT program

Immunization Tracking

Use to indicate parental consent to participate in ImmTrac Immunization Registry.

Modifier	Description
U6	Parental consent to participate in ImmTrac immunization registry

Important: For TMHP to report **written** consented immunization records to *ImmTrac*, medical providers must communicate consent for *ImmTrac* participation when billing for immunizations. After processing claims, TMHP forwards all consented immunization records directly to *ImmTrac*. **A claim will not deny if the "U6" modifier is not on the claim; however, consented immunization records will not be reported to *ImmTrac*.** The letters "U6" are recognized as the modifier used to indicate **written** consent for *ImmTrac* Registry participation.

THSteps Medical Checkup Claims Inquiries

Call the following number to obtain answers to questions or determine the status of claims:

800-757-5691

Hearing Evaluation/Hearing Aid

For children needing these services, refer to the Program for Amplification for Children of Texas (PACT). For THSteps Medicaid clients under the age of 21 Form 3087 will have a "P" in the column under "Hearing Aid," which indicates that prior approval must be obtained from PACT for hearing aid services. Physicians, health department employees, school nurses, teachers, education service center employees, public officials, other state agency employees may refer the parent to the program. The parent of the child may apply for these services through PACT provider or at the following address:

Program for Amplification for Children of Texas
Bureau of Women and Children
Texas Department of Health
1100 West 49th Street
Austin TX 78756-3199
512-458-7724 or
http://ww.tdh.state.tx.us/audio/pactpro.htm

Laboratory

Requests for THSteps supplies from the Texas Department of Health should be made on TDH Form G399 and submitted to:

Specimen Acquisition, Container Preparation & Supplies
Bureau of Laboratories
Texas Department of Health
1100 West 49th Street
Austin TX 78756-3199
Supplies: 512-458-7661, fax: 512-458-7672
Technical Questions: 512-458-7680
Test Results: 512-458-7578

A written request for NBS specimen collection form (NBS-3) and NBS supplies is required. To obtain order form for written requests call:

512-458-7661

Newborn Screening Automated Voice Response System:
Personal identification number required
512-458-7300

PAP smear supplies may be ordered from:

Texas Center for Infectious Disease
2303 Southeast Military Drive
San Antonio TX 78223
Attn: Customer Service
210-531-4596

Tips for successful blood collection:

http://www.tdh.state.tx.us/lab/ccSamcol.htm

Providers who have ordered from the TDH pharmacy and are on its automated system should continue on that system.

Child Health Record

May be downloaded from the THSteps Web site or camera-ready copies may be ordered from:

THSteps Program
1100 West 49th Street
Austin TX 78756-3179

Texas Medicaid Provider Procedures Manual – Texas Health Steps

May be requested from:

THSteps Program
Texas Department of Health
1100 W. 49th Street
Austin TX 78756-3179
512-458-7745

THSteps Web Site

www.tdh.state.tx.us/thsteps/index.htm

Texas Vaccines for Children Program

800-252-9152
www.tdh.state.tx.us/immunize/default.htm

ImmTrac – Texas Immunization Registry

800-348-9158
www.tdh.state.tx.us/immunize/immtrac.htm

MTP – Medical Transportation Program

877-633-8747
www.tdh.state.tx.us/mtp/index.htm

THSteps Outreach & Informing Service
Missed Appointment & Referral Services

877-THSteps (847-8377)

THSteps Education Center
Texas Nurses Association

877-612-8947
www.thsteps.org

Case Management for Children and Pregnant Women Enrollment

512-458-7111 ext. 2168
www.tdh.state.tx.us/caseman/caseman.htm

Early Childhood Intervention

www.eci.state.tx.us

THSteps – CCP

www.tdh.state.tx.us/thsteps/thstepscomprehe.htm

TMHP Web Site

www.tmhp.com

9-25-03

Index

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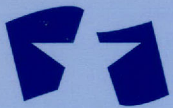

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