UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention Program

Initial Health, Hearing & Vision Assessment

Health Assessment

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

Child Medical History	Family Medical History
Routine prenatal care ☐ Yes ☐ No Maternal Fetal Medicine care ☐ Yes ☐ No **Prenatal exposure to alcohol/smoking/meds/drugs/toxic substances ☐ Yes ☐ No** **At birth: ☐ Stable ☐ Unstable # Days in NICU:** **If premature/NICU: ☐ ECMO ☐ ROP ☐ Oxygen ☐ Vent ☐ Jaundice ☐ Abx** **Other Events: ☐ Hospitalization ☐ Surgery ☐ Injury ☐ ER visit**	☐ Autism ☐ ADHD ☐ Developmental delay ☐ Postpartum depression, depression or anxiety ☐ Trauma or diagnosed mental health conditions ☐ Other childhood or genetic conditions Are you or anyone who knows your child concerned about autism, or do you have any other concerns?

Notes:

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

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

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

Notes:

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

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

Notes:

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

Notes:

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

Notes:

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Health Summary

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

Notes:

Education provided:

Hearing Assessment

Newborn Hearing Screening: □ Pass □ Fail □ Unknown
CMV testing? □ Yes □ No
ENT referral? □ Yes □ No
Family history of childhood hearing loss? □ Yes □ No
Follow-up hearing testing? □ Pass □ Fail
History of ear infections? □ Yes □ No How many?
PE tubes? □ Yes □ No Placement date:
Ear drainage or excessive wax? □ Yes □ No

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

Hearing Summary □ **PASS** □ **REFER** □ **REFER TO USDB-PIP** □ **INCONCLUSIVE**

Assessment	Date	Provider V :	Right Ear	Left Ear
Audiology eval			□ Pass □ Fail	□ Pass □ Fail
OAE			□ Pass □ Fail	□ Pass □ Fail
Tympanogram			□ Pass □ Fail	□ Pass □ Fail

Vision Assessment

Appearance of Eyes

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

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

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

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

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

DOES YOUR CHILD?

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

Notes:

Vision Summary ☐ **PASS** ☐ **REFER** ☐ **REFER TO USDB-PIP** ☐ **INCONCLUSIVE**

Assessment	Date	Provider	Results
Ophthalmology exam			
USDB vision evaluation			
Spot vision screener			