PEDS Core **Required**
Total Questions : 66
Member Details :
Name: Altruista ID:
Date Of Birth: Home Phone:

CONSENT

1 **Do you agree to Case Management services?**
Yes
No

2 **Do you agree to discuss your child's health information with me today?**
Yes
No

3 **Does the member or legal guardian give verbal permission to discuss PHI?**
Yes
No

4 **Does member or authorized legal representative give verbal permission to share the results of this assessment verbally and/or electronically with members of the healthcare team?**
Yes
No

PROMPTS

5 **PROMPT: Verify and update race, ethnicity and language in member details**
Use Quick Links to navigate to Member Details

6 **PROMPT: Enter member height, weight and BMI in health indicators.**
Use Quick Links to navigate to health indicator

OVERALL HEALTH

7 **How would you describe your child's health?**
Excellent
Good
Fair
Poor

8 **What concerns do you have regarding your child's health?**
Describe Concerns

9 **Does your child's health keep him/her from doing the things he/she wants?**
Yes
No

SOCIAL DETERMINANTS

10 **Do you have difficulties (such as transportation, making appointments) that keep you from seeing your PCP or other type of needed provider as frequently as your would like to?**
Yes
No

11 **If yes, why?**
Transportation
Difficulty making or getting an appointment
Cannot afford copay

No PCP
Language barrier
Other
Describe Other Difficulties

12 Do you believe your child's needs are being met through your current support system, i.e. friends, family, faith organization?
Yes
No

CAREGIVER

13 Do you feel the primary caregiver is capable and adequately trained to provide necessary care? OR As the primary caregiver, do you feel adequately trained to provide necessary care?
(Phrasing dependent on response to Q3)
Yes
No

14 Caregiving can certainly become overwhelming. What aspects are you finding most stressful lately? (Please select all that apply)
Not having enough time for myself
Not having enough time with others in my life
Controlling my frustration or anger regarding caregiver responsibility
Feeling out of control
Worsening condition of child
Other
Specify Other

15 Do you have any of the following concerns about your child?
Change in ability to complete ADLs (in past 90 days)
Change in mental status (in past 90 days)
Safety in his/ her residence
Self-injurious behavior
Threatening behavior/ violence toward others
Wandering/Elopement
None

HEARING

16 Is your child deaf or do they have serious difficulty hearing?
Yes
No

VISION

17 Is your child blind or does he/she have serious difficulty seeing, even when wearing glasses?
Yes
No

COGNITION

18 Does your child have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
Yes
No

ADLs

19 Does your child have serious difficulty walking or climbing stairs? (5 years old or older)
Yes
No

20 Does your child have difficulty dressing or bathing? (5 years old or older)
Yes
No

21 Does your child have difficulty doing errands alone such as visiting a doctor's office, shopping, using the telephone, managing your medication? (15 years old or older)
Yes
No

MEDICATION

22 Does your child take prescription medications?
Yes
No

23 Does your child take their medication as prescribed by the doctor?
Yes
No

24 What prevents your child from taking his/her medications as often as prescribed by the doctor?
Can't get to pharmacy
Can't get approved for coverage or excluded in their plan
Can't afford
Experiencing side effects or don't like the way it makes me feel
Forgets to take almost every day
Lack of understanding/knowledge
Hard to keep tracks of multiple medications
Other
Describe Other

HOUSING

25 What is your child's current living environment?
Family Residence
Foster Care/Medical Foster Care
Group Home
Long Term Care Facility
Shelter
Residential Treatment Center
Rehabilitation Facility
Other
Describe Other

ADVANCED DIRECTIVES

26 Have you completed any of the following with or on behalf of your child?
Advance Directive
Psychiatric Advance Directive
Power of Attorney
Living Will

"My Wishes" Booklet
N/A
None of the above

27 Are you interested in receiving some information to review to discuss with your family/child?
Yes
No
Not Now

28 Do you have any beliefs that impact how care should be provided for your child? (e.g.. religious or other feelings and beliefs, such as blood transfusions)
Yes
Describe Beliefs
No

29 Do you have the support available to ensure your preferences are met?
Yes
No

BENEFIT KNOWLEDGE

30 Do you know what your health plan covers for you?
Yes
No

EDUCATION

31 Over the past year, how many days did the member miss preschool/school/work because of illness or injury?
0-5 days
6-10 days
>10 days
N/A (does not attend school or work)

32 What are the reasons the member missed preschool/school/work ?
Illness
Transportation
Skilled nursing unavailable
Classroom aide unavailable
Parent/Natural Support unable to accompany child
Hospitalization
Child refusal
Disciplinary action
Behavioral health issue
Scheduled medical/dental appointments
Other
Describe Other Reasons

PHYSICAL ACTIVITY

33 During the past week, on how many days did your child exercise or participate in any physical activities for at least 20 minutes?
No days per week
1-2 times per week
3 or more times per week
Doesn't know

Not applicable

TOBACCO

34 Does anyone in your household smoke tobacco products?

Yes
No

35 Does the member smoke or use tobacco products?

Yes
No
N/A

HIGH RISK BEHAVIORS

36 Is the member sexually active?

Yes
No
N/A

37 Does the member use alcohol or drugs?

Yes
No
N/A

INFANT

38 Is baby being breast fed?

Yes
No
N/A

39 Is baby experiencing any problems with feeding?

Yes
No
N/A

40 If yes, specify:

Poor nippling, takes too long to eat
Problems nursing
G-tube fed
Problems breathing with feeds, nasal flaring, cyanosis
Gastroesophageal Reflux (GERD) - usually on anti-reflux medication

41 Does baby have any breathing problems?

Yes
No
N/A

42 If yes, describe:

On supplemental oxygen
On apnea monitoring
Cyanosis
Fast breathing
Ventilator / Bipap

TRAUMA

43 Has the child experienced or witnessed an event that caused , or threatened to cause, serious harm to him or herself or to someone else?
Yes
No

44 What was the event?
Car or Other Accident
Fire
Storm
Physical Illness or Assault
Sexual Assault
Other Event
Describe Other Event

45 What age was the member when this event occurred?
Specify Age

46 Child reports more physical complaints such as headaches, stomach aches, nausea when reminded of the event.
Not True (as far as you know)
Somewhat or Sometimes True
Very True
Often True

47 Child avoids doing things that remind him/her of the event
Not True (as far as you know)
Somewhat or Sometimes True
Very True
Often True

48 Child startles easily (jumps when hears sudden loud noises)
Not True (as far as you know)
Somewhat or Sometimes True
Very True
Often True

49 Child gets upset if reminded of the event.
Not True (as far as you know)
Somewhat or Sometimes True
Very True
Often True

HEDIS

50 Are your child's well Child check-ups (EPSDT) up to date?
Yes
No
Don't know

51 Are your child's immunizations up to date?
Yes
No
Don't know

DENTAL

52 Does your child see the dentist for routine preventive services every 6 months?

Yes
No
Don't know

HEDIS

53 Have you/ your child received age appropriate Health Education at each visit?

Yes
No
Don't know

DISASTER PLAN

54 Do you have a plan in place to continue your care in the event of a disaster (such as hurricane, tornado, house fire, flood or snowstorm)?

Yes
No

55 If yes, what is your plan

Will be staying home
Have plan for escape
Will be going to stay with family
Have generator back up power source
Will be going to shelter
Other
Describe Other Plan

EDUCATION

56 Does your child receive any of the following services in community early intervention program or in the school?

Guidance Counseling
Personal Care Attendant
Medication Administration
Physical Therapy
Occupational Therapy
Speech Therapy
Respiratory Therapy
Behavioral Management Services
Individual Behavioral Health Therapy
Group Behavioral Health Therapy
Homebound Services
Extended School Year Program
Assistive Technology
Autism Resource Services
Visual Impairment Support
Multiple Disabilities Support
Other
Please specify other services through school
Doesn't know
None of the above

57 Does your child have a formal plan for receiving services in the community/ school?

Yes
No
Doesn't know

58 Which plan does your child have for school services?

Individualized Family Service Plan (IFSP)
Individualized Education Plan (IEP)
504 Plan

59 What is the name of the coordinator who helped you create the service plan for school or early intervention services?

Enter Document name, agency and contact info
Document Name

60 Is your child's primary care doctor involved with the IEP / IFSP/504 Plan?
Yes
No
Doesn't know

61 Are there any concerns you have regarding the services your child receives at school?
Yes
No
Doesn't Know
N/A

CONDITIONS

62 Have you ever been told your child has one or more of the following medical conditions?

Pediatric Core Health Conditions

- **a. Allergies**
- **b. Pain**
- c. **Immune System** (Body's Defense System)
  - i. Immune Globulin Deficiency (decreased ability to fight disease), Rheumatoid Arthritis (inflammatory disorder of joints)
- d. **Neurologic** (Brain and Nervous System)
  - i. Cerebral Palsy, Hydrocephalus(fluid build-up in brain)/VP Shunt, Paraplegia, Quadriplegia, Seizure Disorder/Epilepsy, Spina Bifida (spinal cord fails to develop or close properly), Spinal Cord Injury, Traumatic Brain Injury (TBI)
- **e. Head, Ear, Nose, Throat**
  - i. Cleft Lip/Palate, Cochlear Implant, Ear Infections, Hearing Impairment, Sinus Problems, Throat Infections
- **f. Eyes/Vision**
  - i. Strabismus/Lazy Eye, Vision Impairment
- **g. Dental**
  - i. Broken Teeth, Bruxism (teeth grinding), Caries, Missing Teeth, Orthodontia
- h. **Endocrine** (Hormones/Glands)
  - i. Diabetes Type1, Diabetes Type 2. Gigantism/Acromegaly, Hypothyroidism, Short Stature/Dwarfism
- i. **Pulmonary** (Lungs)
  - i. Asthma, Brochopulmonary Dysplasia (BPD), Bronchiolitis/Bronchitis, Cystic Fibrosis, Recurrent Pneumonia, RSV, Tuberculosis
- j. **Cardiac/Circulatory** (Heart, Circulatory System)
  - i. Atrial Septal Defect (ASD), Cardiomyopathy (heart disease), Coarctation of Aorta (narrowing of aorta), Double outlet Rt. Ventricle, Dysrhythmias, Heart Murmur, HF (Heart Failure), Hypertension (high blood pressure), Hypoplastic Left Heart, Primary Pulmonary Hypertension, Tetralogy of Fallot, Ventricular Septal Defect (VSD)
- **k. Blood Disorders**
  - i. Hemophilia, HIV/AIDS, Sickle Cell Disease
- **l. Eating Disorders**
  - i. Anorexia, Bulimia, Eating Disorder, Failure to Thrive (inadequate weight gain)
- m. **Gastro-Intestinal** (Esophagus, Stomach, Intestines)
  - i. Gastrostomy Tube (feeding tube), Gastrostomy-Jejunostomy Tube (feeding tube), Obesity/Overweight, Acid Reflux, Colostomy (surgically placed exit for waste in the lower abdomen), Celiac Disease (immune reaction to gluten), Constipation, Chrohn's Disease (inflammatory bowel disease), Diarrhea, GI Motility Disorder, Hepatitis (liver inflammation), Hirschsprungs Disease (condition related to difficulty passing stool), Irritable Bowel Syndrome, Lactose Intolerance, Neurogenic Bowel (lack of nervous control to bowel), Pyloric Stenosis (thickening between stomach and small intestine)

n. **Genito-Urinary** (Reproductive, Urinary, Genitals)
   i. Enuresis (urinary incontinence), GU Reflux, Neurogenic Bladder (lack of nervous control to bladder), Recurrent Urinary Tract Infections, Renal Failure, Urinary Incontinence, Pregnant, Sexually Transmitted Disease (STD)

o. **Orthopedic/Muscular** (Bone and Muscle Disorders)
   i. Amputation, Club Foot, Congenital Hip Dysplasia, Muscular Dystrophy (weakness and loss of muscle mass), Osteomylelitis (bone infection), Scoliosis (spinal curvature)

p. Psychiatric/Behavioral Health
   i. Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Auditory Processing Disorder, Autism or Autism Spectrum Disorder, Bipolar Disorder, Delay in Toilet Training, Depression, Post Traumatic Stress Disorder, Oppositional Defiance Disorder, Schizophrenia, Substance Abuse

q. Other
   i. Specify Other Condition

Allergies
Cleft Lip/Palate
Cochlear Implant
Ear Infections
Hearing Impairment
Sinus Problems
Strabismus/Lazy Eye
Throat Infections
Vision Impairment
Broken Teeth
Bruxism
Caries
Missing Teeth
Orthodontia
Pain
Atrial Septal Defect (ASD))
Cardiomyopathy
Coarctation of Aorta
Double outlet Rt. Ventricle
Dysrhythmias
Heart Murmur
HF
Hypertension
Hypoplastic Left Heart
Primary pulmonary hypertension
Tetralogy of Fallot
Ventricular Septal Defect (VSD)
Asthma
Bronchopulmonary Dysplasia (BPD)
Bronchiolitis/Bronchitis
Cystic Fibrosis
Recurrent Pneumonia
RSV
Tuberculosis
Hemophilia
HIV/AIDS
Immune Globulin Deficiency
Rheumatoid Arthritis
Sickle Cell Disease
Diabetes Type I
Diabetes Type II
Gigantism/Acromegaly
Hypothyroidism
Short Stature/ Dwarfism
Cerebral Palsy
Hydrocephalus/VP Shunt
Paraplegia
Quadriplegia
Seizure disorder/Epilepsy
Spina Bifida
Spinal Cord Injury
Traumatic Brain Injury (TBI)
Anorexia
Bulimia
Eating Disorder
Failure to Thrive
Gastrostomy Tube
Gastrostomy-Jejunostomy Tube
Obesity/Overweight
Acid Reflux
Colostomy
Celiac Disease
Constipation
Crohn's disease
Diarrhea
GI Motility Disorder
Hepatitis
Hirschsprungs Disease
Irritable Bowel Syndrome
Lactose Intolerance

Neurogenic Bowel
Pyloric Stenosis
Enuresis
GU Reflux
Neurogenic Bladder
Recurrent Urinary Tract Infections
Renal Failure
Urinary Incontinence
Pregnant
Sexually Transmitted Disease (STD)
Amputation
Club Foot
Congenital Hip Dysplasia
Muscular Dystrophy
Other
Specify Other Condition
Osteomyelitis
Scoliosis
Anxiety Disorder
Attention Deficit Hyperactivity Disorder
Auditory Processing Disorder
Autism or Autism Spectrum Disorder
Bipolar Disorder
Delay in Toilet Training
Depression
Post Traumatic Stress Disorder
Oppositional Defiance Disorder
Schizophrenia
Substance Abuse

CONSENT

63 Are you ok if we share the information we discussed today with your child's doctor and others who may be involved in your child's care?
Yes
No

CASE MANAGER

64 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member can do the things they need to do to take care of their health?
Extremely
Quite a bit
Somewhat
A little bit
Not at all

65 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member will ask their provider questions and bring up their concerns?
Extremely
Quite a bit
Somewhat
A little bit
Not at all

66 End of assessment