FOR OFFICE STAFF USE ONLY

Healthy Development through Primary Care

Screening & Referral Log

Child's age: ______ Gender: M F

Instrument age interval: _______

Date of screening: ___________

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Type of Screening:

❑ Developmental screening (**ASQ**)

OR

❑ Mental health screening (**ASQ:SE**)

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Result: ❑ Pass ❑ Fail Score: ________

Referred: ❑ Yes ❑ No

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Referred to (check all that apply):

❑ Specialist within clinic system

❑ Specialist outside clinic system

❑ IEIC

❑ School district or ECSE

❑ Other: ______________________________

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Not referred. Other action taken:

❑ Anticipatory guidance, educational materials, parenting resources

❑ Request follow-up visit

❑ Other: ______________________________

Clinic Name

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Healthy Development through Primary Care

Screening & Referral Log

Child's age: ______ Gender: M F

Date of screening: ___________

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Maternal Depression Screening

Tool: **Edinburgh**

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Result: ❑ Pass ❑ Fail Score: ________

Referred: ❑ Yes ❑ No

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Referred to (check all that apply):

❑ Mother's identified primary care provider

❑ Specific primary care provider (new to patient)

❑ Unspecified primary care provider or clinic

❑ Mental health provider

❑ Other:______________________________

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Not referred. List any other action taken:

____

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Clinic Name