M=Medicaid
021=Medicaid pending

Developmental Screening Initiative New Mexico

Chart Audit Tool (and Evaluation Tool)

Date of audit _____

Validated Developmental Screening Tool(s) available in clinic: ☐ no ☐ yes _____ (name)

Date of Visit: _____ Billing: ☐ Medicaid ☐ Medicaid pending ☐ no charge ☐ other

Child's chronological age:_____ (in months) Gestational age at birth: _____ (in weeks)

1. Chronic conditions (pre-existing diagnoses) present?:
☐ YES specify: (1)_____ (2)_____ (3)_____
☐ None

2. Was this visit a routine Well Child Check (WCC)?:
☐ YES WCC Visit in months (circle one): 2 4 6 9 12 15 18 24 30 36 48
☐ NO

3. Was this child already receiving developmental services at time of visit?
☐ YES (agency name) _____
☐ None documented in chart

4. Did this child get a validated developmental screening at this visit?:
☐ YES Name of tool:_____
☐ NO
If yes, for ASQ what age-specific tool was used? _____ (months)
ASQ Screening Scores: _____ (comm.) _____ (gross) _____ (fine) _____ (prob. solv.) _____ (pers-soc)
Other Tool Scores/Results: _____
Specify Tool(s) different from ASQ by name:

ASQ Screening Scores:
Enter raw number and zone for each domain using B for black zone, W for white, and BL for borderline between black and white zones.

5. Was this child referred for **developmental** assessment at this visit?
☐ YES Referral Agency Name: _____
☐ NO and:
- ☐ Plan made to follow development at next visit
- ☐ No development-specific plan documented in chart
- ☐ Referral made previously—developmental assessment report pending
- ☐ Developmental assessment &/or services offered and declined

6. Is there communication from referral agency regarding **developmental** assessment in child's chart?
☐ YES
☐ NO
If yes, for each communication, identify the agency, date, and circle communication type:
Agency_____ Date_____ letter report phone call other
Agency_____ Date_____ letter report phone call other
Agency_____ Date_____ letter report phone call other

5. What other screening was done at this visit? (check all that apply):

- ☐ Hearing
- ☐ Vision
- ☐ Lead level
- ☐ Hematocrit
- ☐ Maternal Depression
- ☐ Social Emotional Development
- ☐ School readiness
- ☐ Other (specify) _____
- ☐ None

6. Referrals other than for developmental assessment generated by this visit? ☐ yes ☐ no
If yes, specify: (1)_____ (2)_____ (3)_____

7. Billing Codes for this visit:_____ _____ _____ _____

Date of next planned visit: _____
Purpose of next visit: _____

<To Be Filled Out By DSI Team, NOT by Site/Clinic Auditor>

Child's Current Age:_____ (months)
Adjusted Age*:_____ (months)

Validated developmental screening appropriately performed (correct age-specific tool, scored):
☐ yes
If yes, select one of the following:
O All scores indicate child doing well
O1 or more scores indicate further evaluation needed
☐ no
If no, select one of following:
O No documentation of tool use/used found
O Documentation found, but not correct age-specific tool
O Correct tool used, but incomplete
Circle one: Not scored Other_____

☐ Validated developmental screening performed but specifics (e.g., tool age, scores) unavailable

Response based on score:
☐ All scores indicated child doing well and no referral
☐ At least one score indicated further evaluation needed and:
O Referral was made
O Clinical decision was to follow and follow up visit:
☐ Successfully completed around 1 month (+/- 1 week)
☐ Successfully completed **beyond** 5-week post-screening period
☐ Not successfully completed
O No plan or action documented
☐ No score(s) available

Communication from referral agency regarding developmental assessment dated after referral was present in chart: ☐ yes ☐ no ☐ not applicable (no referral made)

*Note: *Adjust for prematurity until chronological age of 2 ½ years if less than 32 weeks gestation at birth; adjust for prematurity until chronological age of 2 years if 32-37 weeks gestation at birth. No adjustment necessary if birth was at 38 weeks gestation or older.*