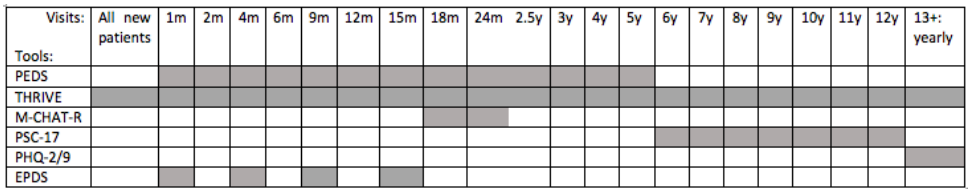
CHPCC Screening Schedule										
	6m	9m	18m	1y	2y	3y	4y	5y	9-11	17-21
Fluoride Varnish		X								
Non-Fasting LDL + HDL									X	X

BMC Clinic Screening Questionnaire Schedule



Autism Management in Primary Care Clinic* (CHOP EBG)	
Who to Screen	Children ages 12 months or older (AAP recommends screening at 18 mo and 24mo or 30mo) ▪ Risk factors for ASD: sibling w/ ASD, unusual social responses, genetic disorder
How to Screen	PEDS questionnaire @ every visit: "Do you have any concerns about your child's development or behavior?" MCHAT-R or MCHAT-R/F (modified checklist for autism in toddlers) @ 18mo, 24mo
Developmental Red Flags	• Diminished, atypical, or no babbling by 12 months • Diminished, atypical, or no gesturing (e.g., pointing, waving bye-bye) by 12 months • Lack of response to name by 12 months • No single words by 16 months • Diminished, atypical, or no two-word spontaneous phrases (excluding echolalia or repetitive speech) by 24 months • Loss of any language or social skill at any age • Lack of joint attention
Positive Screening – What Now?	• Formal audiology testing • EI referral (<5 years old)(EI services end at 2 years and 9 months • DBP clinic referral for all • Other specialty referrals as needed
Follow Up	• 1 month after positive screening w/ primary provider for continuity • Ensure EI referral was placed, answer family questions, make sure school is involved for children > 2.9 years

ADHD*	
EBGs	ADHD, adolescents; ADHD, pre-school and school-age
ADHD Definition	Persistent and pervasive inattention, hyperactivity, and/or impulsivity affecting cognitive, academic, behavioral, emotional, and social functioning **in more than one setting.**
How to Screen	Age >/= 4 years: Vanderbilt Assessment Scales (**Diagnostic)** (print from internet) ▪ To be filled out by parent and teacher ▪ Obtain detailed information from teacher, including report cards, review of IEP
Common Coexisting Disorders	• Learning disabilities • Tic disorders • Anxiety • Depression • OCD • ODD • Substance abuse
Additional Evaluation PRN	Consider speech/language eval as appropriate ▪ OT/PT referral if motor deficits ▪ Mental health referral ▪ Labs/imaging if risk factors for alternate organic diagnosis: • Blood lead levels, TSH, neuroimaging, EEG

ADHD Treatment (age 6+) in Primary Care Clinic (adapted from BCH EBG)	
Criteria for Initiation of Pharmacotherapy	Confirmation of diagnosis as above: ▪ Age >6 ▪ No allergy to medication ▪ Normal HR, BP ▪ No hx seizures, tourette syndrome, PDD, significant anxiety d/o
Medication Considerations and Recommendations	• Obtain hx of cardiovascular disease (no EKG needed if hx unremarkable) • Consider length of school day, homework, after school activities: ▪ Intermediate release 4-8 hours ▪ Extended release 10-12 hours
Recommended Starting Med (at lowest dose)	Metadate CD 10mg ▪ if cannot swallow pills, few after school demands (sprinkle on food) Metadate ER (Concerta) 18mg ▪ if can swallow pills, extended coverage for afterschool **Paper prescriptions will need to be written monthly
Side Effects	HA, insomnia, anorexia, tics, abdominal pain, HTN
When to Follow Up	Give family Vanderbilt forms to be filled out by teacher/parent, bring to f/u visit Schedule follow up visit for **2 weeks**
2 Week Follow Up Visit	**Improved, minimal side effects**: continue at current dose, return in 1 month **No improvement, minimal side effects:** increase dose on current med, f/u 1-2 weeks ▪ if time of day dependent, consider adding immediate release in late afternoon **Improvement/stable symptoms, significant side effects:** ▪ Severe side effects- change med to equiv dose (e.g.; MPH —> AMP) ▪ Mild side effects- continue current medication, return in 1 month ****Always evaluate for co-morbid dx:** depression, tics, ODD/CD, anxiety
Maintenance/ Other Considerations	• Follow up every 3-6 months when symptoms stable on medication w/ tolerable side effects • Consider starting immediate release for pts <6y OR to find optimal med prior to starting long acting version