

Crown Colony Pediatrics

CONGRATULATIONS ON YOUR NEW BABY!!!

We would like to welcome you to Crown Colony Pediatrics.



**500 CONGRESS STREET
SUITE 1F
QUINCY, MA 02169
(617) 471-3411**

NEW PATIENT REGISTRATION

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

PRENATAL HISTORY

Total # Pregnancies _____ # Live Births _____ # Living Children _____ # Still Births _____ # Miscarriages _____

Were you sick during this pregnancy? Yes No

What hospital was the baby born at? _____

During this pregnancy did you have:

Baby's birth weight _____

German Measles Yes No

Was child born early on time overdue

Unexplained rash Yes No

Length of labor under 2 hours over 12 hours

Anemia Yes No

Difficulty at delivery Yes No

Sexually Transm'd Disease Yes No

Breech Cesarean

Protein in urine test Yes No

Other problems _____

Kidney Infections Yes No

Anesthesia Yes No

Injuries/Accident Yes No

Awake at birth Yes No

Bleeding/Spotting Yes No

Did baby fail to cry immediately Yes No

Excessive weight gain Yes No

Was baby in special nursery Yes No

High blood pressure Yes No

Was baby in hospital longer than mom Yes No

Diabetes Yes No

Other _____

RH problem Yes No

When did you seek prenatal care 1st trimester

X-Ray Yes No

2nd trimester 3rd trimester not at all

Did you smoke/drink alcohol/or use drugs Yes No

During this pregnancy were you ever hospitalized? Yes No

Take vitamins and/or iron Yes No

If yes, reason _____

Other medications (Please List): _____

-See over-

Other

FAMILY HISTORY: INDICATE IF ANY OF THE FOLLOWING ARE IN THE FAMILY. CHILD'S GRANDPARENTS, AUNTS, UNCLAS, BROTHERS OR SISTERS

DISEASE PROBLEM		RELATIONSHIP	DISEASE PROBLEM		RELATIONSHIP		
YES <input type="checkbox"/>	NO <input type="checkbox"/>	HYPERTENSION		YES <input type="checkbox"/>	NO <input type="checkbox"/>	ASTHMA/HAY FEVER, ECZEMA	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEART DISEASE		YES <input type="checkbox"/>	NO <input type="checkbox"/>	MENTAL ILLNESS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	KIDNEY TROUBLE		YES <input type="checkbox"/>	NO <input type="checkbox"/>	BIRTH DEFECTS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	TUBERCULOSIS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	MENTAL RETARDATION	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	DIABETES		YES <input type="checkbox"/>	NO <input type="checkbox"/>	SCHOOL PROBLEMS	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	CANCER/TUMORS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	POOR VISION, HEARING, SPEECH	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	CONVULSIONS/EPILEPSY		YES <input type="checkbox"/>	NO <input type="checkbox"/>	ALCOHOL DEPENDENCY	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	BLEEDING PROBLEMS		YES <input type="checkbox"/>	NO <input type="checkbox"/>	DRUG DEPENDENCY	
YES <input type="checkbox"/>	NO <input type="checkbox"/>	ANEMIA/SICKLE CELL		YES <input type="checkbox"/>	NO <input type="checkbox"/>	OTHER INHERITED DISEASE	

SOCIAL HISTORY FAMILY CONSTELLATION

YEARS AT PRESENT ADDRESS _____ SINGLE PARENT VS TWO PARENTS _____

LIVING WITH SOMEONE OTHER THAN NATURAL PARENT _____

FAMILY CONSTELLATION

NAME	RELATIONSHIP	AGE	OCCUPATION	PLACE OF EMPLOYMENT	LIVING IN HOME YES/NO
	MOTHER				YES <input type="checkbox"/> NO <input type="checkbox"/>
	FATHER				YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>
					YES <input type="checkbox"/> NO <input type="checkbox"/>

PRIMARY LANGUAGE OF FAMILY _____ RACE _____ ETHNICITY _____

WOULD YOU LIKE TO TALK TO ONE OF THE PHYSICIANS ABOUT: OTHER FAMILY NEEDS FOR HEALTH CARE

BIRTH CONTROL FAMILY FINANCE HOUSING FAMILY PROBLEMS MARTIAL PROBLEMS

DAY CARE SCHOOL OTHER _____

HEALTH NEEDS ASSESSMENT

Patient Name:		Patient Date of Birth:
Your Name:		Relationship to Patient:
Preferred Language:		

		Please circle
	In the last 12 months, did you or your family ever eat less than you felt you should because there wasn't enough money for food?	Yes / No
	Are you worried that in the next 2 months you may not have stable housing?	Yes / No
	Think about the place where you live. Do you have problems with any of the following? Pests (mice or roaches), mold, no/not working smoke detectors, water leaks, no window guards.	Yes / No
	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Yes / No
	In the last 12 months, have you or your family ever had to go without health care because you didn't have a way to get there?	Yes / No
	Are you or your family worried about feeling safe in your home?	Yes / No
	Do you have concerns about your/your child's learning or behavior in school, preschool or daycare?	Yes / No
	Do you feel that you need more support from other people or programs to help you care for yourself or your family?	Yes / No
	Do you need help understanding your or your child's healthcare needs (diagnosis, medications, plan, etc.)?	Yes / No
	In the last 12 months, was there a time when your child needed to see a doctor or get medications or supplies but could not because of cost?	Yes / No
	Did you or your child miss school or work because of a health problem that could have been avoided?	Yes / No

	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	Yes / No
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Comments:		

PATIENT DEMOGRAPHIC FORM

CHILDREN IN HOUSEHOLD	DATE OF BIRTH	GRADE LEVEL

PARENT/GUARDIAN'S INFORMATION

Name:	Name
Relationship:	Relationship:
Date of Birth:	Date of Birth:
Address	Address:
Email:	Email:
Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home
Work Phone:	Work Phone:
Insurance:	Subscriber:
Insurance ID:	
Emergency Contact (cannot be parent)	
Name:	Relationship to Patient:
Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Secondary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home

- I HEREBY AUTHORIZE NEGATIVE LAB/XRAY RESULTS TO BE REPORTED TO ME VIA EMAIL/MY CHART
- I UNDERSTAND THAT CROWN COLONY PEDIATRICS BELIEVES STRONGLY IN THE SAFETY AND EFFICACY OF IMMUNIZATIONS AND MY CHILD WILL RECEIVE IMMUNIZATIONS AS RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS. CROWN COLONY PEDIATRICS DOES NOT ACCEPT OR KEEP PATIENTS/FAMILIES WHO REFUSE TO VACCINATE
- I HAVE RECEIVED CROWN COLONY PEDIATRICS IMMUNIZATION SCHEDULE
- I HEREBY AUTHORIZE BILLING VIA ELECTRONIC SUBMISSION AND PAYMENT DIRECTLY TO THE OFFICE FOR PROFESSIONAL SERVICES RENDERED AND I SHALL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO THIS OFFICE. CO-PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT. THE OFFICE RESERVES THE RIGHT TO ADD BILLING CHARGES TO ACCOUNTS AFTER SIXTY DAYS AND ANY ACCOUNTS FORWARDED TO COLLECTION SERVICES WILL BE SUBJECTED TO AN ADDITIONAL 1/3 CHARGE ADDED TO THE ACCOUNT. I AUTHORIZE THE ATTENDING PHYSICIAN TO RELEASE INFORMATION CONCERNING THE EXAMINATION AND TREATMENT OF MY CHILD (FOR INSURANCE PURPOSES ONLY)
- I AM GRANTING PERMISSION FOR CROWN COLONY PEDIATRICS TO VIEW MY CHILD'S PRESCRIPTION HISTORY FROM EXTERNAL SOURCES
- I HAVE RECEIVED YOUR NOTICE OF PRIVACY PRACTICES AND/OR I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT
- I AGREE THAT TELEPHONE MESSAGES REGARDING MY APPOINTMENTS, PRESCRIPTION REFILLS, LAB RESULTS, AND ALL OTHER PROTECTED HEALTH INFORMATION (PHI) MAY BE LEFT FOR ME ON VOICEMAIL SYSTEMS AND ANSWERING MACHINES AT THE TELEPHONE NUMBERS I PROVIDED TO YOU
- I UNDERSTAND AND AGREE THAT **ONLY A PARENT OR LEGAL GUARDIAN CAN ACCOMPANY MY CHILD TO THEIR PHYSICALS/ANNUAL WELL VISITS**

By Signing below, you agree to the above statements:

Signature of Parent/Guardian: _____ Date: _____



Beata Brzozowska, M.D. | Barbara E. Angus, M.D. | Lisa Corkins, M.D.
Lisa Natkin, M.D. | Molly Urquhart, M.D.

Authorization to Release Mother’s Medical Records to Crown Colony Pediatrics

Mother’s Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Home Email: _____

I HEREBY AUTHORIZE _____
TO RELEASE FULL CONTENT OF MEDICAL RECORDS, INCLUDING ALL TEST RESULTS AND RECORDS RECEIVED FROM
PRIOR PHYSICIANS TO CROWN COLONY PEDIATRICS.

Signature _____ Date: _____

THE MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, VENERAL DISEASE,
ABORTION, OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION
IS RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Signature _____ Date: _____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERNING HIV TESTING AND/OR AIDS DIAGNOSIS OR
TREATMENT. SEPARATE CONSENT IS REQUIRED TO HAVE THIS INFORMATION RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Signature _____ Date: _____



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Authorization to Release Patient’s Medical Records to Crown Colony Pediatrics

Patient’s Name: _____ Date of Birth: ____/____/____

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Home Email: _____

I HEREBY AUTHORIZE _____
TO RELEASE FULL CONTENT OF MEDICAL RECORDS, INCLUDING ALL TEST RESULTS AND RECORDS RECEIVED FROM
PRIOR PHYSICIANS TO CROWN COLONY PEDIATRICS.

Patient/Parent/Guardian Signature _____ Date: _____

THE MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, VENERAL DISEASE,
ABORTION, OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION IS
RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERNING HIV TESTING AND/OR AIDS DIAGNOSIS OR
TREATMENT. SEPARATE CONSENT IS REQUIRED TO HAVE THIS INFORMATION RELEASED.

I CONSENT TO HAVE THIS INFORMATION DISCLOSED.

Patient/Parent/Guardian Signature _____ Date: _____



Dr. Beata Brzozowska, M.D. | Dr. Barbara E. Angus, M.D. | Dr. Lisa Corkins, M.D.
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NEWBORN INFORMATION

OFFICE HOURS:	Monday – Thursday	8AM – 7PM, 5PM – 7PM <i>Sick Only</i>
	Friday	9AM – 5PM
	Saturday	9AM – 4PM <i>Sick Only</i>
	Sunday	Closed

Immunizations

Our office follows the guidelines of the American Academy of Pediatrics.

Feeding and Elimination

Full term newborn infants must feed approximately every 2-3 hours, at a minimum. Vitamin D supplementation is recommended aside from any infant who has special medical needs. Most newborns who are formula fed should receive a cow milk-based iron supplemented formula such as SIMILAC or ENFAMIL. Your infant should have a minimum of 6 wet diapers daily. The frequency of stooling will vary greatly and will initially appear dark green/tarry (Meconium) and process to pasty or seedy stools within a few days.

Sleeping

Most newborn infants will sleep for the majority of the 24 hours in a day, taking their sleep in short periods and awakening to be fed. The current recommendation of the Academy of Pediatrics is to have infants sleep on their back in a crib or bassinet without loose blankets.

Umbilical Care

The stump of the umbilical cord just needs to be kept clean and dry, and free from excessive irritation (e.g. the edge of the diaper). Infants should have only sponge baths (not to be immersed in water) until the stump has detached. If the stump is not detached by 14-21 days of life, or if at any time it appears inflamed, has discharge, or bleeding, you should contact our office.

Circumcision Care

The individual who perform the circumcision on your son will provide instruction regarding its care during the healing process. Usually, all that is involved is to apply ointment such as Vaseline that the healing edge of skin does not adhere to or become irritated by the diaper. If you believe the circumcision is not healing correctly, or if there are any signs of infection or excessive bleeding please contact our office.

Jaundice

Jaundice (a yellow coloration of the skin, eyes, mucous membranes) is a common condition in many newborns sometime in the first several days of life. Most cases of jaundice just require close observation to ensure that the bilirubin (the chemical that causes jaundice) in the blood does not reach overly high levels. If your infant appears jaundiced you should contact us to have him/her checked.

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Infant Safety

Car safety seats are not only essential, but are also required by law in Massachusetts for any child less than 8 years old or less than 57 inches. You must have a car seat for your infant for the ride home from the hospital and for every car ride thereafter. Infant car seats must be backward facing and be able to be anchored safely. We can provide you with information regarding approved infant car seats. Infants must never be left unattended on any surface above the floor. Even the smallest infant can move enough to fall, and even seat belts, straps, or rails on infant chairs or changing tables are not secure enough to prevent falls. Infant chairs or changing tables are not secure enough to prevent falls. Likewise, infants should never be left unattended in a bassinet, sink, or bathtub.

As prevention against burn, the hot water temperature in your home should be adjusted to 120° or less.

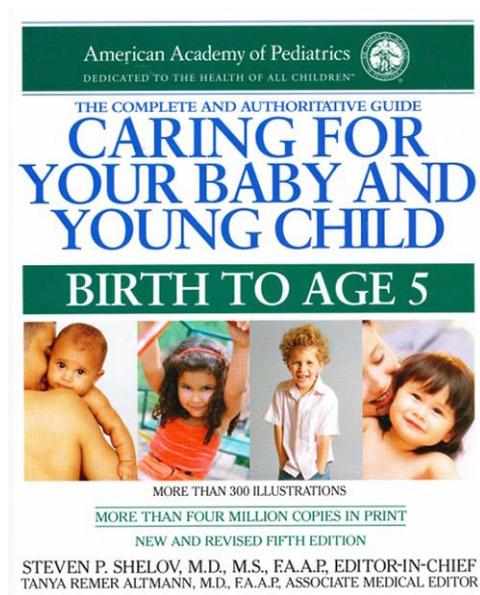
Temperature

You should be familiar with taking a rectal temperature on your infant prior to discharge from the hospital. A rectal thermometer should be lubricated with a small amount of lubricant such as petroleum jelly. The thermometer should be inserted into the rectum such that the bulb is completely covered (approximately ½ inch), and kept in for two minutes. If you are unsure of this procedure or how to read the thermometer, please ask us or one of the nursery nurses. Any rectal temperature over 100° or less than 97° should be reported to us. Please do not give any medications (including acetaminophen – Tylenol, Tempura) to your infant without consulting with us first.

Other

Please do not hesitate to call if you have any questions concerning your infant or his/her care. We will always be available to provide advice, general information, and references on a wide variety of topics. There is a nurse assigned to answer routine questions from 9-5, Monday thru Friday. For emergencies you may call at any time. Also, you can visit our website www.crowncolonypediatrics.com for frequently asked questions.

The first routine office visit for most infants is within 1-2 days of discharge. We will advise you at the time of discharge of when to make your first office appointment.





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SEPARATION AND DIVORCE POLICY

Crown Colony Pediatrics is dedicated to the health and well-being of our patients. Since our patients are young children and adolescents, we rely on parents/guardians to support us in their care. Separation and divorce can present our practice with unique challenges; therefore, it is important for us to articulate our practice philosophy to avoid misunderstandings.

1. In general, we ask that parents/guardians NOT place our office in the middle of family disagreements. If parents/guardians become disruptive to our organization or there is non-compliance with this policy, we reserve the right to terminate the patient/doctor relationship so care can be transferred to another practice.
2. Either parent or legal guardian can schedule an appointment for their child, be present for a visit, have access to the child(ren)'s MyChart portal, and/or obtain copies of medical records unless a COURT ORDER has been presented to our office RESTRICTING a parent/guardian's rights. If you have a court order, please provide a copy to our office immediately upon receiving. If the court order changes at any point, it is your responsibility to provide us with an updated copy. We will assume the last copy we have on file is the current agreement/order.
3. We are contractually obligated to collect copays at the time of a visit. Therefore, the parent/guardian that brings the child in for an appointment is responsible for the copays or insurance deductibles at the time of service, even if the other parent/guardian is responsible for medical insurance. We will NOT mediate financial disputes between parents. Any disputes about reimbursement for medical expenses need to be settled between parents/guardians.
4. A parent/guardian must accompany a child to WELL VISITS. If a stepparent should bring your child in for these visits, we must have a "Consent for Treatment" on file with that adult's name within the past year. In circumstances when it is unclear whether the attending adult has the right to consent or treat, we may call you for a on-time authorization, or we reserve the right to require the well visit to be rescheduled to a time a parent/guardian can be present.
5. Additionally, we will NOT:
 - a. Call the non-accompanying parent/guardian for consent prior to treatment or inform the other parent/guardian whenever visits are scheduled.
 - b. Restrict either parent/guardian's involvement in your child(ren)'s care unless authorized by law.
 - c. Tolerate appointment scheduling/cancelling (or no show) patterns of behavior between parents.
 - d. Call the non-accompanying parent/guardian following visits. It is the responsibility of the accompanying parent to communicate with the other parent/guardian about the patient's care and any relevant information regarding follow up care for the child.



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Vaccine Policy

Our Commitment to Your Child's Health

At **Crown Colony Pediatrics**, your child's health and safety are our top priority. Vaccines are one of the most effective ways to protect your child, your family, and our community from serious diseases. We follow the immunization schedule recommended by the **American Academy of Pediatrics (AAP)** and the **Massachusetts Department of Public Health**. This schedule provides the best protection at the safest times in your child's life.

Our Practice Policy

Because vaccines are so essential to children's health, **we are only able to accept families who follow the recommended vaccination schedule.**

If you have questions or concerns about vaccines, please speak with one of our doctors **before scheduling an appointment.**

Vaccine Safety and Effectiveness

Vaccines are one of the greatest medical achievements of the past century. Decades of research confirm that vaccines are **safe, effective, and do not cause autism or other developmental disabilities.**

We do not recommend delaying or splitting vaccines, as doing so may leave your child unprotected. For this reason, our office **does not offer alternative vaccine schedules or split versions of combination vaccines.**

Learn More

For more information about vaccines, their safety, and the recommended immunization schedule, visit the **American Academy of Pediatrics** at www.aap.org



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NO SHOW/LATE CANCELATION POLICY

Crown Colony Pediatrics defines a “no show” as any appointment you do not cancel at least 24 hours in advance when you are not able to keep it. Canceling in advance allows us the opportunity to give that appointment slot to someone else who needs it. We feel that continuity of care is very important, thus please find our detailed “no show” policy below:

Initial No Show:

Patients who no show for the first time will be sent a postcard reminder

Second No Show:

Patients who no show for a second time will be sent a letter reminding them of the policy and a warning that if they no show a third time, they may be asked to find a new medical practice.

Third/Final No Show:

Patients who no show for a third time may be asked to leave the practice and find a new pediatrician. We will see the patient for 4 weeks for urgent care and follow-up visits only and will be happy to work with the patient to get them the medical records needed so they can transition smoothly to a new practice.



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Vitamin K Administration Policy

In alignment with our vaccination policy and the standard of newborn care, it is our office policy that all newborns must receive injectable vitamin K prior to hospital discharge. Without this essential vitamin which supports proper blood clotting; some babies are at risk for severe bleeding, which can result in irreversible brain damage or even death. The preferred method for newborns to receive Vitamin K is through a one-time injection into the baby's thigh.

To learn more about vitamin K, please visit the American Academy of Pediatrics or heathychildren.org.



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ZERO TOLERANCE FOR ABUSIVE BEHAVIOR POLICY

Our Commitment to a Safe Environment for Patient and Our Staff

Our practice is committed to maintaining a safe, respectful and professional environment for all patients, families and staff members. We have a strict ZERO TOLERANCE POLICY for any form of abusive behavior, including but not limited to:

We value every patient and staff member and are committed to:

- No verbal abuse, including shouting, swearing, threats or derogatory remarks, insults, or any language deemed disrespectful or harmful.
- No physical aggression or intimidation.
- No harassment or discriminatory comments based on race, gender, religion, ethnicity, or any other protective characteristic.

We understand that medical situation can be stressful. However, aggressive or abusive behavior towards staff is not acceptable under any circumstances. If such behavior occurs, the following actions may be taken:

- Individuals exhibiting abusive behavior will be asked to leave the premises immediately.
- Continued abusive behavior may result in dismissal of the practice.

We value our patients and are committed to providing high quality care in a safe and supportive environment. We expect all interactions within our practice to be conducive to mutual respect and professionalism.

We appreciate your cooperation in creating a positive atmosphere for everyone. Thank you for your understanding.

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AGE	VACCINE	PROCEDURES	GUIDANCE	SCREENING TOOLS
1-2 Weeks	Hep B IF NOT GIVEN AT THE HOSPITAL	WT, HT, HC	Info Sheet 1-2 Weeks Temperature Taking, Hep B Info Sheet	PHQ- 2 (MATERNAL)
1 Month		WT, HT, HC		SWYC PHQ- 2 (MATERNAL) HNA
2 Months	Vaxelis (DTAP, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 2 Months Tylenol/Temperature, Taking VIS	SWYC PHQ- 2 (MATERNAL)
4 Months	Vaxelis (DTAP, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 4 Months Solid Foods, VIS	SWYC PHQ- 2 (MATERNAL)
6 Months	Vaxelis (DTAP, IPV, HIB, Hep B) PCV20 Rotateq	WT, HT, HC	Info Sheet 6 Months VIS	SWYC PHQ- 2 (MATERNAL)
9 Months		WT, HT, HC TB Risk Screening	Info Sheet 9 Months Choking Info, Poison Control, VIS	SWYC
12 Months (Must be after 1 year Birthday)	MMR Varivax Hep A	HGB, PB (lead), Spot Vision TB Risk Screening	Info Sheet 12 Months, VIS	SWYC HNA
15 Months	Pentacel (DTAP, IPV, HIB) PCV20	WT, HT, HC TB Risk Screening	Info Sheet 15 Months, VIS	SWYC
18 Months	Hep A Hep A MUST BE MINIMUM OF 6 MONTHS AFTER Hep A #1 12 MONTHS	WT, HT, HC TB Risk Screening	Info Sheet 18 Months, VIS	SWYC M-CHAT
2 Years		WT, HT, HC, HGB, PB, Spot Vision TB Risk Screening	Info Sheet 2 Years Toilet Training	SWYC M-CHAT HNA
3 Years		WT, HT, BP, HGB, Pulse, PB (Lead) Spot Vision TB Risk Screening	Safety Information	SWYC HNA
4 Years	Quadracel (DTAP, IPV, MMRV)	WT, HT, BP, HGB, Pulse PB (lead) if at risk* Spot Vision/Hearing *lives in high risk community or previous high lead TB Risk Screening		SWYC HNA
5 Years		WT, HT, BP, Pulse, Hearing TB Risk Screening		SWYC HNA

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500 Congress St, Ste 1F Quincy, MA 02169

Immunization Schedule

(617) 471-3411 | www.crowncolonypediatrics.com

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AGE	VACCINE	PROCEDURES	GUIDANCE	SCREENING TOOLS
*6-8 Years		WT, HT, BP, Pulse Near Vision (LEA symbols) Passing 20/32 or better & stereopsis Hearing at 6, 8 TB Risk Screening		PSC-17 *(8 YR OLD ONLY SUDDEN CARDIAC SCREEN EVENT SCREEN) HNA
9-10 Years	HPV #1 at 9 HPV #2 at 10	WT, HT, BP, Pulse Vision only at 9 Vision/Hearing at 10 TB Risk Screening		PSC-17 HNA
*11 -12 Years	Tdap MenQuadfi *HPV #2 (*if #1 not given at 9)	WT, HT, BP, Pulse Vision Cholesterol Screening TB Risk Screening		PSC-17 Y PSC – Parent *(11 YR OLD ONLY SUDDEN CARDIAC SCREEN EVENT SCREEN) HNA
*13-17 Years	Check if HPV Complete	WT, HT, BP, Pulse TB Risk Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PHQ-4 (<i>If Positive, Add PHQ-9, GAD7</i>) *(14 & 17 YR OLD ONLY SUDDEN CARDIAC SCREEN EVENT SCREEN) PSC - Parent HNA
16 Years	MenQuadfi Booster Men B #1	WT, HT, BP, Pulse (HGB, females only) Cholesterol Screening TB Risk Screening GC/Chlamydia Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PHQ-4 Y (<i>If Positive, Add PHQ-9, GAD7</i>) PSC – Parent HNA
*17 Years	Men B #2	WT, HT, BP, Pulse TB Risk Screening GC/Chlamydia Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PHQ-4 Y (<i>If Positive, Add PHQ-9, GAD7</i>) *(SUDDEN CARDIAC SCREEN EVENT SCREEN) PSC – Parent HNA
18 Years		WT, HT, BP, Pulse TB Risk Screening GC/Chlamydia Screening	BSE/TSE Exam Aid Info Age Appropriate Info Sheets VIS	PHQ-4 (<i>If Positive, Add PHQ-9, GAD7</i>) HIPAA Consent Form (Aging Out of Practice Information)
ASTHMATIC				ACT FORM
ANXIETY/ DEPRESSION				GAD-7 PHQ-9

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