

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: \_\_\_\_\_ Gestational age at birth: \_\_\_\_\_  
(in months) (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:

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

- |  |   |
|--|---|
| <input type="checkbox"/> Hearing             | <input type="checkbox"/> Social Emotional Development |
| <input type="checkbox"/> Vision              | <input type="checkbox"/> School readiness             |
| <input type="checkbox"/> Lead level          | <input type="checkbox"/> Other (specify) _____        |
| <input type="checkbox"/> Hematocrit          | <input type="checkbox"/> None                         |
| <input type="checkbox"/> Maternal Depression |   |

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:

All scores indicate child doing well

01 or more scores indicate further evaluation needed

no

If no, select one of following:

No documentation of tool use/used found

Documentation found, but not correct age-specific tool

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:

Referral was made

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

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.*