

Childhood Record



Saskatchewan
Health Authority



Name: _____
(last name) (first name)

Health Services Number _____

Birthdate: _____ Sex: _____
(yyyy/mm/dd)

Mother: _____ YOB: _____

Father: _____ YOB: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (H) _____ (C) _____

Email: _____

EPD Score		
Postnatal	2 months	6 months
<input type="checkbox"/> N/Declined	<input type="checkbox"/> N/Declined	<input type="checkbox"/> N/Declined
<input type="checkbox"/> Y Score <input type="text"/>	<input type="checkbox"/> Y Score <input type="text"/>	<input type="checkbox"/> Y Score <input type="text"/>

Early Childhood Assessment Form

Encounter Date (yyyy/mm/dd)						
Age						
Immunization Only (✓)						
General Health	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Parental Concern	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Targeted Questions -2m - EPDS -4m - Nutrition -6m - EPDS -12m Development -18m - Speech and Language -4yr - Social Behavior	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Growth	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Feeding Relationship	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Breastfeeding	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF
Formula Feeding/Milk (type)	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Nutrients of Concern (Vitamin D)	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Elimination	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Complementary Feeding	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Oral Health	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP

PHC Saskatoon Urban-BF Survey

Between 2 months and less than 4 months – Actual age of infant: ____ Is your baby receiving any breastmilk currently? No Yes

- During the past 7 days, has your baby received water, non-human milk/formula, other liquids, or solids? No Yes (Non-exclusive)
- Has your baby ever received water, other fluids (including formula), or solids since birth? No (Exclusive) Yes (Non-exclusive)

Between 4 months and less than 6 months – Actual age of infant: ____ Is your baby receiving any breastmilk currently? No Yes

- During the past 7 days, has your baby received water, non-human milk/formula, other liquids, or solids? No Yes (Non-exclusive)
- Has your baby ever received water, other fluids (including formula), or solids since birth?
 No (Exclusive) Yes (Non-exclusive)

Between 6 months and less than 7 months – Actual age of infant: ____ Is your baby receiving any breastmilk currently? No Yes

- During the past 7 days, has your baby received water, non-human milk/formula, other liquids, or solids? No Yes (Non-exclusive)
- Did you introduce complementary foods prior to 6 months of age? No (Exclusive) Yes (Non-exclusive)

Between 12 months and less than 16 months – Actual age of infant: ____
 Is your baby receiving any breastmilk currently? No Yes

Handouts	Given/Not Given	Given/Not Given	Given/Not Given	Given/Not Given	Given/Not Given	Given/Not Given
PHN Signature						

Code for charting screening/counselling: NA: Not assessed (only applies to Standard Assessments) NAP: No Apparent Problem REF: Referred
 CLS: Closed – referral completed, concern no longer exists OBS: Observe for future referral UCC: Under Continued Care by another health professional
Breastfeeding: EXB: exclusive NEB: non-exclusive NBF: no breastfeeding X: see narrative for comments XM: see mother's rec

