

NOTES

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
 2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "[The Prenatal Visit](#)."
 3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
 4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "[Breastfeeding and the Use of Human Milk](#)." Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "[Hospital Stay for Healthy Term Newborn Infants](#)."
 5. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped. See "[Use of Chaperones During the Physical Examination of the Pediatric Patient](#)."
 6. Screen per "[Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report](#)."
 7. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
 8. Oral Health Services by the primary care provider include oral health assessments, fluoride varnish applications, and referral to a Dental Home. An oral health assessment (Risk Assessment Tool: [English](#) | [Spanish](#)) is a required component of a preventive health visit to a primary care provider for children prior to the establishment of a primary dental provider. Children should be referred to a primary dental provider beginning within 6 months of the eruption of the first tooth and should have an established dental home by no later than age 3 years. Primary dental providers should deliver all aspects of a child's oral health care in a comprehensive, continuously accessible, and coordinated way by a single dental practice.
 9. Perform a [risk assessment](#). See "[Maintaining and Improving the Oral Health of Young Children](#)."
 10. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption up to age 5 (see [statement](#)). Once teeth are present, fluoride varnish must be applied to all children every three to six months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "[Fluoride Use in Caries Prevention in the Primary Care Setting](#)." Fluoride varnish should be applied two times per year and up to four times per year, depending on patient risk for caries. DC Medicaid covers fluoride varnish applied by primary care clinicians for children under three years old. To bill for fluoride varnish application for children under 3 years old, use CPT code 99188.
 11. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "[Visual System Assessment in Infants, Children, and Young Adults by Pediatricians](#)" and "[Procedures for the Evaluation of the Visual System by Pediatricians](#)."
 12. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "[Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs](#)."
 13. Verify results as soon as possible, and follow up, as appropriate.
 14. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "[The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies](#)."
 15. Screening should occur per "[Promoting Optimal Development: Identifying Infant and Young Children with Developmental Disorders Through Developmental Surveillance and Screening](#)." Developmental surveillance is the process of recognizing children who may be at risk of developmental delays and should be performed at every well-child visit. Developmental screening is the administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder, and is required at 9, 18, and 30 months. To bill for a developmental screening using a structured validated tool as a part of the preventive care visit, use CPT code 96110.
 16. Screening should occur per "[Identification, Evaluation, and Management of Children with Autism Spectrum Disorder](#)."
 17. Screen for behavioral and social-emotional problems per "[Promoting Optimal Development: Screening for Behavioral and Emotional Problems](#)," "[Mental Health Competencies for Pediatric Practice](#)," "[Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders](#)," and "[Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative](#)." The screening should be family centered and may include asking about caregiver emotional and mental health concerns as well as social determinants of health, racism, poverty, and relational health. See "[Poverty and Child Health in the United States](#)," "[The Impact of Racism on Child and Adolescent Health](#)," and "[Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health](#)." If a child is identified as requiring further mental health services or treatment, please refer to "[The DC Collaborative for Mental Health in Pediatric Primary Care's Child and Adolescent Mental Health Resource Guide](#)."
 18. A recommended screening tool is the [CRAFT Screening Tool](#).
 19. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "[Guidelines for Adolescent Depression in Primary Care \(GLAD-PC\): Part I. Practice Preparation, Identification, Assessment, and Initial Management](#)," "[Mental Health Competencies for Pediatric Practice](#)," "[Suicide and Suicide Attempts in Adolescents](#)," and "[The 21st Century Cures Act & Adolescent Confidentiality](#)."
 20. Screening should occur per "[Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice](#)."
 21. These may be modified, depending on entry point into schedule and individual need.
 22. See the [Immunization Schedules](#), per the AAP Committee on Infectious Diseases and DC Health's [Immunization Division Resident Website](#).
 23. District of Columbia law requires all newborns to have a blood test for all conditions defined in the District of Columbia Newborn Screening Act. For a full list of conditions that should be tested for go to [Chapter 4: Newborn Screening](#). *Understanding Genetics: A District of Columbia Guide for Patients and Health Professionals*: Results should be reviewed at visits and appropriate retesting or referral done as needed. In addition to District-required Newborn blood lead tests, the newborn bilirubin and critical congenital heart defect tests should be completed.
 24. Blood lead level testing (a BLL screening test) is a required part of a well-child visit at 12 months and 24 months of age for all children eligible for DC Medicaid. District law requires a BLL screening test for all children between 6 months and 14 months of age and another BLL screening test between 22 months and 26 months of age. District law requires immediate reporting by laboratories and providers to DC Health of any child with an elevated BLL at or above 3.5 µg/dL. Timely reporting of elevated BLL's allows DC Health to promptly offer case management and risk mitigation assistance. The provider's report must be made either to DC Health's secure fax line at (202) 535-2607 or by telephone to [DC Health's Childhood Lead Poisoning Prevention Program](#) at (202) 481-3837. Providers are also able to access laboratory results, including BLL screening status and the results for each child with whom they have a treatment relationship through the Designated DC Health Information Exchange (HIE), [CRISP DC](#), which receives automatic data feeds from the DC Lead Registry. *(Continued in next column)*.
- (Continued from previous column)*. Providers are able to access a dedicated population health analytics dashboard in the HIE, which allows them to view the percentage of all children within their practice two years of age or older who had one or more capillary or venous lead blood tests indicating lead poisoning. Providers are able to access CRISP DC through its web-based portal or through single sign-on within their electronic health record system. For children at risk of lead exposure, see "[Prevention of Childhood Lead Toxicity](#)" and "[Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention](#)."
25. Between the ages of 36 months and 72 months, children enrolled in Medicaid must receive a blood lead test if they have not previously been tested twice for blood lead levels. Unless the provider has evidence of the child's receipt of two blood lead tests, blood lead testing must be performed. The obligation continues until the child reaches age 21 if assessment during a screen causes the provider to suspect lead poisoning.
 26. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
 27. See "[Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents](#)."
 28. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done on recognition of high-risk factors.
 29. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first). See USPSTF [Cervical Cancer Screening recommendations](#). Indications for pelvic examinations prior to age 21 are noted in "[Gynecologic Examination for Adolescents in the Pediatric Office Setting](#)."
 30. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
 31. Adolescents should be screened for HIV according to the USPSTF [HIV Infection Screening recommendations](#) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
 32. Perform a risk assessment for hepatitis B virus (HBV) infection according to [recommendations per the USPSTF](#) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
 33. All individuals should be screened for hepatitis C virus (HCV) infection according to the [USPSTF recommendations](#) and [Centers for Disease Control and Prevention \(CDC\) recommendations](#) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
 34. Perform a risk assessment, as appropriate, per "[Sudden Death in the Young: Information for the Primary Care Provider](#)."