

TODDLER ASSESSMENT (2-3 Years)

Name:	Assessment Start Date:
DOB:	Assessment End Date:
Age:	Physician:
Gender:	School Name:
PHN:	Phone:
Home Address:	

Infant/Toddler/Pre-School Generic

ASSESSMENT ITEM CODES

NC = Normal/No Concern C = Concern (progress note-infant/toddler/preschooler required) X = Not Assessed

Date

Age of Child

Contact Type

Location

Assessment Items

Growth	X	X	X	X
Feeding/Nutrition	X	X	X	X
Method of Feeding				
Elimination	X	X	X	X
Sleep	X	X	X	X
Safety	X	X	X	X
Skin	X	X	X	X
Mouth Care/Dental	X	X	X	X
Immunization Issues	X	X	X	X
Vision	X	X	X	X
Gross Motor Development	X	X	X	X
Fine Motor Development	X	X	X	X
Social Emotional Development/ Attachment	X	X	X	X
Speech/Language Development/Hearing	X	X	X	X
Behaviour	X	X	X	X
Parenting	X	X	X	X
Daycare/Preschool	X	X	X	X
Health Follow-up	X	X	X	X
Other Concerns	X	X	X	X

Completed By

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2 Year / 3 Year

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☐ Anticipatory Guidance Provided

Date _____

Age of Child _____

Contact Type _____

Location _____

Assessment Items	2 Years	3 Years
Growth	X	X
	<input type="checkbox"/> Normal Growth	<input type="checkbox"/> Normal Growth
Feeding/Nutrition	X	X
	<input type="checkbox"/> 3 meals/3 snacks	<input type="checkbox"/> 3 meals/3 snacks
	<input type="checkbox"/> Canada Food Guide	<input type="checkbox"/> Canada Food Guide
	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Food allergies
	<input type="checkbox"/> Limit juices/sugar	<input type="checkbox"/> Limit juices/sugar
	<input type="checkbox"/> Feeding relationships	<input type="checkbox"/> Feeding relationships
Elimination	X	X
	<input type="checkbox"/> Range of patterns/colour/consistency	<input type="checkbox"/> Range of patterns/colour/consistency
	<input type="checkbox"/> Toilet Training	<input type="checkbox"/> Toilet Training
Sleep	X	X
	<input type="checkbox"/> Sleep/wake patterns	<input type="checkbox"/> Sleep/wake patterns
	<input type="checkbox"/> Bedtime routine	<input type="checkbox"/> Bedtime routine
Safety	X	X
	<input type="checkbox"/> Car seat	<input type="checkbox"/> Booster car seat (20 kg)
	<input type="checkbox"/> Falls	<input type="checkbox"/> Traffic/bike safety
	<input type="checkbox"/> Traffic/bike safety	<input type="checkbox"/> Playground safety
	<input type="checkbox"/> Playground safety	<input type="checkbox"/> Suffocation/choking
	<input type="checkbox"/> Suffocation/choking	<input type="checkbox"/> Burns
	<input type="checkbox"/> Burns	<input type="checkbox"/> Water safety
	<input type="checkbox"/> Water safety	<input type="checkbox"/> Child proof home/poisons
	<input type="checkbox"/> Child proof home/poisons	<input type="checkbox"/> Stranger safety
	<input type="checkbox"/> Stranger safety	<input type="checkbox"/> 2nd hand smoke
	<input type="checkbox"/> 2nd hand smoke	

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Skin	X <input type="checkbox"/> Skin care <input type="checkbox"/> Sun exposure	X <input type="checkbox"/> Skin care <input type="checkbox"/> Sun exposure
Mouth Care/Dental	X <input type="checkbox"/> Early childhood tooth decay <input type="checkbox"/> Flouride toothpaste <input type="checkbox"/> Dental visits	X <input type="checkbox"/> Early childhood tooth decay <input type="checkbox"/> Flouride toothpaste <input type="checkbox"/> Dental visits
Immunization Issues	X <input type="checkbox"/> Immunization schedule <input type="checkbox"/> Vaccine preventable diseases <input type="checkbox"/> Use of Health Passport	X <input type="checkbox"/> Immunization schedule <input type="checkbox"/> Vaccine preventable diseases <input type="checkbox"/> Use of Health Passport
Vision	X <input type="checkbox"/> Vision check at 3 <input type="checkbox"/> Indicators of abnormal vision	X <input type="checkbox"/> Vision check at 3 <input type="checkbox"/> Indicators of abnormal vision
Gross Motor Development	X <input type="checkbox"/> Expected milestones for age e.g. - Walking up and down stairs - Kick ball - Runs but falls frequently <input type="checkbox"/> Supportive activities for caregivers	X <input type="checkbox"/> Expected milestones for age e.g. - Pedals Tricycle - Runs well - Walks on tiptoe <input type="checkbox"/> Supportive activities for caregivers
Fine Motor Development	X <input type="checkbox"/> Expected milestones for age e.g. - Stacks blocks - Helps with undressing - Uses spoon <input type="checkbox"/> Supportive activities for caregivers	X <input type="checkbox"/> Expected milestones for age e.g. - Undresses self - Cuts with scissors - Copies circles/lines <input type="checkbox"/> Supportive activities for caregivers
Social Emotional Development/Attachment	X <input type="checkbox"/> Expected milestones for age e.g. - Enjoys other children - Engages in parallel play - Copies play of other children <input type="checkbox"/> Supportive activities for caregivers	X <input type="checkbox"/> Expected milestones for age e.g. - Understands feelings - Uses imagination in play - Co-operative play - Starts to share <input type="checkbox"/> Supportive activities for caregivers

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Speech/Language Development/Hearing	X	<input type="checkbox"/> Expected milestones for age e.g.	X	<input type="checkbox"/> Expected milestones for age e.g.
		- Says up to 50 words		- Uses plurals
		- Starts to name body parts		- Uses 3-4 word sentences
		- 2 word phrases		- Follows directions with several steps
		- May be difficult to understand		- Asks why
		- Understands questions/commands		- Sings songs and rhymes
		- Follows simple directions		
		<input type="checkbox"/> Supportive activities for caregivers		<input type="checkbox"/> Supportive activities for caregivers
		<input type="checkbox"/> Risk factors for hearing loss		<input type="checkbox"/> Risk factors for hearing loss
Behaviour	X	<input type="checkbox"/> May start tantrums/challenging behaviours	X	<input type="checkbox"/> Starts to fight over objects
				<input type="checkbox"/> Starts rebellion "go away"
Parenting	X	<input type="checkbox"/> Positive discipline	X	<input type="checkbox"/> Positive discipline
		<input type="checkbox"/> Parenting resources		<input type="checkbox"/> Parenting resources
Daycare/Preschool	X	<input type="checkbox"/> Selecting appropriate childcare	X	<input type="checkbox"/> Selecting appropriate childcare
		<input type="checkbox"/> Registering for Preschool		<input type="checkbox"/> Registering for Preschool
Health Follow-up	X	<input type="checkbox"/> Recommended health follow-up	X	<input type="checkbox"/> Recommended health follow-up
		<input type="checkbox"/> When to seek medical attention		<input type="checkbox"/> When to seek medical attention
Other Concerns	X		X	
Completed By				

Growth Chart

Date Measured	Age	--- Weight --- kg %ile	--- Height --- cm %ile	--- BMI --- %ile	----- Head ----- Circumference cm %ile	---% Birth --- Wgt Lost	-- Wgt for -- Length %ile	--- Waist --- cm	--- Hip --- ratio
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Casenote

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----