

**Illinois Department of Public Health  
Newborn Screening Program  
Long-term Annual Follow-up Report**

Client's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Dr. \_\_\_\_\_

Confirmation Number: \_\_\_\_\_  
Type: \_\_\_\_\_

1. **Are you currently caring for this child.** Yes \_\_\_ No \_\_\_  
(If No, and the child is known to be under the care of another physician, please provide new physician's name and contact information)  
Name of New Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
(If No, and this child is lost to follow-up, please check here) \_\_\_

2. **Current address of the child's parents:**  
Name(s) of Parent(s): \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

3. **Please complete the following:**  
Current Treatment: \_\_\_\_\_  
Treatment Compliance: Good \_\_\_ Needs Improvement \_\_\_ Poor \_\_\_  
Number of Diagnosis Related Hospitalizations in past 12 months: \_\_\_

4. **Physical Assessment:** Date of Last Assessment \_\_\_\_\_  
Weight \_\_\_\_\_ kg. Percentile for Weight \_\_\_\_\_  
Height \_\_\_\_\_ cm. Percentile for Height \_\_\_\_\_  
Head Circumference \_\_\_\_\_ cm. Percentile for Head Circumference \_\_\_\_\_ (if age 2 years, or less)  
Body Mass Index \_\_\_\_\_ BMI Percentile \_\_\_\_\_  
Tanner Stage (Pubertal Development): Stage 1 \_\_\_ Stage 2 \_\_\_ Stage 3 \_\_\_ Stage 4 \_\_\_ Stage 5 \_\_\_  
Hearing: Normal \_\_\_ Impaired \_\_\_ Assisted \_\_\_  
Vision: Normal \_\_\_ Impaired \_\_\_ Corrected \_\_\_ Cataracts: Yes \_\_\_

5. **Developmental Assessment:**  
Language Development: Within Normal Limits WNL \_\_\_ Delayed \_\_\_ Grossly Delayed \_\_\_  
Psychological Development (Age Appropriate) WNL \_\_\_ Delayed \_\_\_ Grossly Delayed \_\_\_  
Progress in School: Not Applicable \_\_\_ WNL \_\_\_ Delayed \_\_\_ Grossly Delayed \_\_\_  
  
Is Child enrolled in Speech Therapy program? Yes \_\_\_ No \_\_\_  
Is Child enrolled in Early Intervention? Yes \_\_\_ No \_\_\_  
Is Child enrolled in Special Education program? Yes \_\_\_ No \_\_\_

6. **Do you feel that this family might benefit from a home visit by a public health nurse?**  
Yes \_\_\_ If yes, please suggest goal of visit, or reason for concerns in comments below.  
No \_\_\_

7. **Additional Comments:**

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_