

Healthy Families New York/Home Visiting Program Follow Up Information

Complete this form when the target child is 6 months old, 1 years old, 2 years old, 3 years old, 4 years old, and 5 years old. Also complete the form at time of discharge from the program

1. Primary Caretaker 1's Identifier <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/> Last Name (3 let) </div> <div style="text-align: center;"> <input type="text"/> FI </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> Birth Date (Month/Day/Yr) </div> <div style="text-align: center;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> Date of Intake (Month/Day/Yr) </div> </div>	2. Home Visitor's Name <div style="display: flex; justify-content: space-between;"> <div style="width: 60%; text-align: center;">First</div> <div style="width: 35%; text-align: center;">Last</div> </div>
3. Date form completed <div style="display: flex; justify-content: center; gap: 10px;"> <input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </div>	4. Follow-up interval (Indicate target child's age) <input type="checkbox"/> 6 months old <input type="checkbox"/> 1 year old <input type="checkbox"/> 2 years old <input type="checkbox"/> 3 years old <input type="checkbox"/> 4 years old <input type="checkbox"/> 5 years old <input type="checkbox"/> At discharge <input type="checkbox"/> Check here if Prenatal Discharge
5. Was a primary caretaker 2 living in this household at <u>intake</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No (Skip all items in Primary Caretaker 2 column)	

	Primary Caretaker 1	Primary Caretaker 2
6. Is participant living in household at time of follow-up?	<input type="checkbox"/> Yes (Complete all items in PC1 column ↓) <input type="checkbox"/> No (Skip all items in PC1 column)	<input type="checkbox"/> Yes (Complete all items in PC2 column ↓) <input type="checkbox"/> No (Skip all items in PC2 column)
7. Marital status	<input type="checkbox"/> 1. Married <input type="checkbox"/> 2. Not Married	<input type="checkbox"/> 1. Married <input type="checkbox"/> 2. Not Married
8. Did participant hold a job at any time since intake (if this is the 6-month follow-up) or since the last follow-up?	<input type="checkbox"/> Yes (Skip Q9 and fill in PC1 Job information below) <input type="checkbox"/> No (Answer Q9 and skip Family Jobs)	<input type="checkbox"/> Yes (Skip Q9 and fill in PC2 job information below) <input type="checkbox"/> No (Answer Q9 and skip Family Jobs)
9. If PC held no jobs in the follow-up period, did s/he look for a job during this period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Jobs

(Complete this section only if you answered "Yes" in Q8 for Primary Caretaker 1 and/or Primary Caretaker 2.
If there are more than five jobs to report, use the Additional Family Jobs for Follow-up Form)

Participant (Check one)	Date Job Began (mm/dd/yy)	Still at Job?	Date Job Ended (mm/dd/yy)	Hours per week	Average Wages per week	
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1. before taxes <input type="checkbox"/> 2. after taxes
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1. before taxes <input type="checkbox"/> 2. after taxes
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1. before taxes <input type="checkbox"/> 2. after taxes
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1. before taxes <input type="checkbox"/> 2. after taxes
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1. before taxes <input type="checkbox"/> 2. after taxes

Date Form Submitted	Reviewer's Initials	Date of Data Entry	Initials of Data Entry Operator

Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)				Date of Intake (Month/Day/Yr)							

Educational Status and Involvement in Educational, Employment and Training Programs

	Primary Caretaker 1	Primary Caretaker 2
10. Highest grade completed as of this follow-up (check only highest level)	<input type="checkbox"/> 1. Less than 8 <input type="checkbox"/> 2. 8-11 <input type="checkbox"/> 3. HS Grad <input type="checkbox"/> 4. GED <input type="checkbox"/> 5. Vocational school after HS	<input type="checkbox"/> 6. Some college <input type="checkbox"/> 7. Associates degree <input type="checkbox"/> 8. Bachelors degree or higher
11. Has participant been involved in an educational or employment and training program since intake (if this is 6-month follow-up) or since the last follow-up?	<input type="checkbox"/> Yes (Complete section Family Educational, Employment and Training Programs below ↓) <input type="checkbox"/> No (Go to Q12)	<input type="checkbox"/> Yes (Complete Family Educational, Employment and Training Programs below ↓) <input type="checkbox"/> No (Go to Q12)

Family Educational, Employment and Training Programs

(Complete this section only if you answered "Yes" in Q11 for Primary Caretaker 1 and/or Primary Caretaker 2)

Participant (Check one)	Program Type (See codes below)	Identify Program by Name
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/>	Specify
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/>	Specify
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/>	Specify
PC1 <input type="checkbox"/> PC2 <input type="checkbox"/>	<input type="text"/> <input type="text"/>	Specify

Program Type Codes:	6 College	8 Job search or job placement
1 Jr. high	7 Vocational training, technical or trade school (not counting training received during HS)	9 Work experience
2 HS	10 Other (Specify _____)	
3 GED	5 Adult education in basic math and reading	

Primary Caretaker 1's Current Issues

(Check "Y" for yes if: Primary Caretaker 1 tells you that she/he has a particular issue; someone else like the assessment worker, friend or relative reports the issue; or you observe or suspect the issue exists but no one has discussed it with you. Check "N" for no if the issue is not present. Check "UK" for unknown if you do not know. You must check only one box for each issue listed.)

Are any of the following current issues for the Primary Caretaker 1? (Check all items with either Y or N or UK)

Y	N	UK		Y	N	UK	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Homelessness or inadequate housing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Criminal activity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Physical disability/health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Other legal problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Social isolation/inadequate social support
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Other mental illness/disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Stress or emotional difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Developmental disability/retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Inadequate food, clothing, or household goods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Marital or relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Other (Specify _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Financial difficulties/insufficient Income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)				Date of Intake (Month/Day/Yr)							

CPS Reports

29. Did Home Visiting Staff make a report to CPS on this family since last intake if this is the 6 month Follow-up or since the last follow-up? Yes No

Public Benefits

30. Is family receiving any of the following benefits since intake (if this is the 6-month follow-up) or since the last follow-up? Yes (answer Q31-Q35) No (skip to Q36)

	31. TANF	32. Food Stamps	33. Emergency Assistance	34. WIC	35. SSI/SSD
1. Currently receiving	1. <input type="checkbox"/>	1. <input type="checkbox"/>	1. <input type="checkbox"/>	1. <input type="checkbox"/>	1. <input type="checkbox"/>
2. Received since last follow-up but not currently receiving	2. <input type="checkbox"/>	2. <input type="checkbox"/>	2. <input type="checkbox"/>	2. <input type="checkbox"/>	2. <input type="checkbox"/>
3. No receipt since last follow-up	3. <input type="checkbox"/>	3. <input type="checkbox"/>	3. <input type="checkbox"/>	3. <input type="checkbox"/>	3. <input type="checkbox"/>

TANF Services Application/Certification

36. Does this Family Meet the Criteria to Receive TANF Services on the Target Child's Yearly Birthday for this Family?
 Yes No (If No, Answer Q37 →)

37. If No is Answered in Q36, Why Doesn't this Family Meet the Criteria to Receive TANF Services?
 1. Income above 200% of Poverty
 2. Immigration Status
 3. Refused to complete application
 4. Other Reason (Specify _____)

Breastfeeding (includes exclusive breastfeeding as well as any combination of breast milk, water, vitamins, formula, solid food, or other non-breast milk nutrition in the target child's diet.)

38. How Many Months has the Target Child been Breastfed since Birth? Months

Family's Medical Provider

A medical provider might be a private physician or a clinic. The major distinction here is whether the individual has someplace other than the emergency room where she/he can go to receive medical care.

	Primary Caretaker 1	Target Child(ren)
39. Does Family Member have a Medical Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health Insurance Coverage for Primary Caretaker 1 and Target Child

Check *all* the health insurance programs that the PC1 or target child are covered by on the date of this follow-up

40. Primary Caretaker 1	41. Target Child
<input type="checkbox"/> Yes <input type="checkbox"/> No 1. Medicaid (Specify CIN #:) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No 1. Medicaid (Specify CIN #:) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No 2. PCAP (Specify CIN #:) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No 2. Child Health Plus <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Private Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Other (Specify _____) <input type="checkbox"/> Yes <input type="checkbox"/> No 5. No health insurance coverage
<input type="checkbox"/> Yes <input type="checkbox"/> No 3. Child Health Plus <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Private Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Other (Specify _____) <input type="checkbox"/> Yes <input type="checkbox"/> No 6. No health insurance coverage	

Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)						Date of Intake (Month/Day/Yr)					

Primary Caretaker 1's Subsequent Children

42. Did Primary Caretaker 1 give birth to any children since the last follow-up?
 Yes (Go to Q43 ↓) No (Go to Q44)

43.

Child First Name	Child Last Name	Child DOB	Term Status
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Full Term <input type="checkbox"/> Premature
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Full Term <input type="checkbox"/> Premature
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Full Term <input type="checkbox"/> Premature

Primary Caretaker 1 Emergency Room Visits and Hospitalizations

If Primary Caretaker 1 had more than seven emergency room visits or more than seven hospitalizations during the period, use an additional page.

44. PC1 Emergency Room Visits

Date of Emergency Room Visit (MM/DD/YY)	Reason for Visit <i>(Please use only 30 characters to describe the visit. Do not use codes)</i>
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
<input type="text"/>	

45. PC1 Hospitalizations (overnight stays)

Date Admitted (MM/DD/YY)	Number of Nights Spent in the Hospital	Reason for Visit <i>(Please use only 30 characters to describe the visit. Do not use codes)</i>
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	

Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)				Date of Intake (Month/Day/Yr)							

Target Child Emergency Room Visits

46. How many times did the target child(ren) visit the emergency room since intake if this is the 6 month follow-up or since the last follow-up? Enter 0 for none.

Number of visits to emergency room this period

Circle below ↓ up to five primary reasons for the visits listed in Q46
Please use the following guidelines when choosing the primary reasons:
 Most serious, most specific and diagnosis over symptoms

<p>Accident/Injury 01 Animal bite, scratch, etc. 02 Bleeding/Cut/Stitches 03 Bruising 04 Burn 05 Caught finger 06 Choking 07 Concussion, Skull Fracture 08 Dislocation/Fracture/Broken bone 09 Dislodge object from ear, nose or skin 10 Injured head, neck or face 11 Fall 12 Other Accident/Trauma 13 Poisoning (ingesting and/or inhaling) 14 Shaken Baby Syndrome, Child Abuse 15 Sprain 16 Swallowing object</p> <p>Breathing Problem 17 Apnea 18 Asthma 19 Bronchitis 20 Cold/Congestion/Sinus Problems 21 Cough/Croup/Pertussis/Whooping Cough 22 Pneumonia 23 RSV (respiratory syncytial virus) 24 Stopped or had trouble breathing/wheezing 25 Upper Respiratory Infection</p>	<p>Infection 26 Bacterial infection 27 Blood Infection/Sepsis 28 Chicken pox, Measles, Mumps 29 Ear infection (earache) 30 Eye infection (conjunctivitis, pinkeye) 31 Flu 32 Fungal infection 33 Hepatitis 34 Herpes 35 HIV/AIDS 36 Impetigo 37 Meningitis 38 Strep throat, Laryngitis, Tonsillitis 39 Thrush/Yeast infection 40 Urinary tract infection (bladder/kidney infection) 41 Viral infection (stomach, etc.)</p> <p>Non Infectious Illness 42 Anemia/Sickle Cell 43 Allergic reaction to bite, food, immunization, medicine, or other 44 Blocked Tear Duct 45 Circumcision and all related concerns 46 Congenital Abnormality/Birth Defect 47 Heart Problems/Stroke 48 Hernia 49 Hydro encephalitis 50 Jaundice 51 Kidney Problem 52 Seizure/Convulsion 53 Teething</p>	<p>General Symptoms/Conditions 54 Abscess, Blisters, Boils, Cysts 55 Crying 56 Concerns about eating, sleeping, toileting patterns 57 Constipation 58 Dehydration 59 Diarrhea 60 Failure to Thrive/Weight Loss 61 Fever 62 Obstruction in Bowel/Intestine 63 Obstruction in Trachea 64 Prematurity 65 Rash/Eczema 66 Scabies, Lice 67 Stomach Ache/Abdominal Pain 68 Sore Throat 69 Vomiting</p> <p>Procedures 70 Blood Transfusion 71 Doctor ordered tests or procedures 72 Feeding Tube 73 Follow up care 74 Surgery, Ear, Nose or Throat 75 Surgery, Eye 76 Surgery, Intestinal 77 Surgery, Other</p>
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Primary Caretaker 1's Identifier

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name (3 let)			FI	Birth Date (Month/Day/Yr)						Date of Intake (Month/Day/Yr)					

Target Child Hospitalization (Overnight Stays) Visits

47. How many times did the target child(ren) stay in the hospital overnight since intake if this is the 6 month follow-up or since the last follow-up? Enter 0 for none.

<input type="text"/>	<input type="text"/>
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Number of overnight hospital stays this period

Circle below ↓ up to five primary reasons for the visits listed in Q47
Please use the following guidelines when choosing the primary reasons:
 Most serious, most specific and diagnosis over symptoms

<p>Accident/Injury</p> <p>01 Animal bite, scratch, etc. 02 Bleeding/Cut/Stitches 03 Bruising 04 Burn 05 Caught finger 06 Choking 07 Concussion, Skull Fracture 08 Dislocation/Fracture/Broken bone 09 Dislodge object from ear, nose or skin 10 Injured head, neck or face 11 Fall 12 Other Accident/Trauma 13 Poisoning (ingesting and/or inhaling) 14 Shaken Baby Syndrome, Child Abuse 15 Sprain 16 Swallowing object</p> <p>Breathing Problem</p> <p>17 Apnea 18 Asthma 19 Bronchitis 20 Cold/Congestion/Sinus Problems 21 Cough/Croup/Pertussis/Whooping Cough 22 Pneumonia 23 RSV (respiratory syncytial virus) 24 Stopped or had trouble breathing/wheezing 25 Upper Respiratory Infection</p>	<p>Infection</p> <p>26 Bacterial infection 27 Blood Infection/Sepsis 28 Chicken pox, Measles, Mumps 29 Ear infection (earache) 30 Eye infection (conjunctivitis, pinkeye) 31 Flu 32 Fungal infection 33 Hepatitis 34 Herpes 35 HIV/AIDS 36 Impetigo 37 Meningitis 38 Strep throat, Laryngitis, Tonsillitis 39 Thrush/Yeast infection 40 Urinary tract infection (bladder/kidney infection) 41 Viral infection (stomach, etc.)</p> <p>Non Infectious Illness</p> <p>42 Anemia/Sickle Cell 43 Allergic reaction to bite, food, immunization, medicine, or other 44 Blocked Tear Duct 45 Circumcision and all related concerns 46 Congenital Abnormality/Birth Defect 47 Heart Problems/Stroke 48 Hernia 49 Hydro encephalitis 50 Jaundice 51 Kidney Problem 52 Seizure/Convulsion 53 Teething</p>	<p>General Symptoms/Conditions</p> <p>54 Abscess, Blisters, Boils, Cysts 55 Crying 56 Concerns about eating, sleeping, toileting patterns 57 Constipation 58 Dehydration 59 Diarrhea 60 Failure to Thrive/Weight Loss 61 Fever 62 Obstruction in Bowel/Intestine 63 Obstruction in Trachea 64 Prematurity 65 Rash/Eczema 66 Scabies, Lice 67 Stomach Ache/Abdominal Pain 68 Sore Throat 69 Vomiting</p> <p>Procedures</p> <p>70 Blood Transfusion 71 Doctor ordered tests or procedures 72 Feeding Tube 73 Follow up care 74 Surgery, Ear, Nose or Throat 75 Surgery, Eye 76 Surgery, Intestinal 77 Surgery, Other</p>
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