



CARE FOR KIDS



Early & Periodic Screening, Diagnosis & Treatment

Volume 10 • Number 3 • Fall 2003

Identifying the Child Victim of Abuse or Neglect

PROTOCOLS FOR ASSESSMENT

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<http://www.uihealthcare.com/childprotection/>

In 2002, Prevent Child Abuse Iowa reported that 12,295 Iowa children were abused. This is a decline of 4% from 2001 — a year that set an all-time high for the number of abused children in Iowa. But even with that decline, the 2002 Prevent Child Abuse Iowa statistics are sobering. Last year:

- 9,162** Iowa children suffered neglect (were denied critical care)
- 2,151** Iowa children were physically injured
- 904** Iowa children were sexually abused
- 468** Iowa children were present during the manufacture of illegal drugs
- 397** Iowa children had illegal drugs present in their systems (mostly newborns, due to prenatal drug use by mothers)



Health care providers have an ethical and legal responsibility to recognize and appropriately care for children who are being abused or neglected. It is often up to the health care provider to initiate a humane cascade of services to protect the child, stop the abuse, and apprehend the perpetrator.

Red flags for child abuse

A health care provider needs to recognize the red flags that can signal abuse or neglect. These indicators may be behavioral or physical. If a child's caregivers cannot give a reasonable explanation for the presence of such an indicator, this is in itself a red flag.

Health care providers need to recognize the red flags that can signal abuse or neglect.

Red flags for physical abuse include:

- Injuries, including fractures and bruises at different stages of healing
- Injuries to the genitalia or anus
- Presence of sexually transmitted diseases, such as chlamydia, gonorrhea, syphilis, HIV

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- Fractures, specifically of the metaphyses (ends of the shafts of long bones), ribs, vertebrae, sternum, scapulae
- Head injury with subdural hematoma
- Retinal hemorrhage
- Cerebral edema
- Complex skull fracture
- Laceration or hematoma of the liver or spleen
- Perforation of the intestines, stomach, or bladder
- Chronic, unexplained enuresis or encopresis
- Patterned injuries that indicate what was used to inflict damage:
 - ◆ Clearly demarcated scald burns
 - ◆ Symmetrical burns of the extremities
 - ◆ Burns to the buttocks
 - ◆ Adult bite marks
 - ◆ Contusions in finger-tip patterns

Red flags for neglect include:

- Failure to thrive, small size for age, falling behind in height, weight
- Emaciated appearance
- Abandonment
- Constant hunger
- Poor hygiene
- Inappropriate clothing for weather
- Lack of medical care for conditions like asthma, diabetes mellitus, dental caries
- Child reports there is no caretaker at home
- Lack of supervision has exposed the child to injury, risk, intoxication

If you see any of these red flags, you need to answer two questions:

1. Is the history provided for a condition consistent with the mechanism, type, and extent of the condition observed?
2. If the child or a third party (for example, a sibling, another child in day care) is cited as the cause of an "accident," is s/he developmentally capable of having caused the condition in the way described by the caregiver?

If the answer is no to either question, do a full work-up to rule out child abuse and neglect. Guidelines for such work-ups are provided on pages 5 and 6.

Diagnostic Guidelines

The initial diagnostic work-up that a health care provider performs is of utmost importance. It often determines how well Child Protective Services and law enforcement will be able to protect the child and prosecute the perpetrator. The guidelines below and on pages 5 and 6 can be used to standardize the diagnostic work-up when child abuse or neglect is suspected.



Diagnostic Work-Up: Suspected Physical Abuse

For children younger than 2 years old, a skeletal survey should be carried out whenever abuse is suspected. For children between the ages of 2 and 5 years, a skeletal survey should be done when abuse or neglect are strongly suspected. With children older than 5 years, x-rays should be taken of skeletal areas that are sources of concern or complaint. Depending on what is learned during the surveys, additional assessment may be needed. See page 5 for more information on components of the skeletal survey and additional tests.

If sexual abuse is suspected, perform a skeletal survey if the child has visible, acute injuries. Children should be tested for sexually transmitted diseases if:

- Genital, oral, or anal contact with the perpetrator's secretions has occurred
- Physical evidence exists of genital, oral, or anal trauma
- Genital or anal discharge is present
- The history regarding the extent of contact is not reliable

(continued from page 2)

You will find more detailed information on assessing childhood sexual abuse in the summer 2003 issue of this newsletter.

Diagnostic Work-up: Suspected neglect

If you suspect a child is experiencing neglect or the denial of critical care, begin by performing a skeletal survey as you would if you suspected physical abuse. Depending on what you learn, additional assessment may be needed; more information is provided on page 6.

Emotional abuse

If you have concerns about emotional abuse, it is wise to refer the child to mental health professional who can assess the child.

What to do if you suspect a child has been abused

If you suspect abuse, Iowa law requires you to file an abuse report with the Iowa Department of Human Services (DHS) within 24 hours of noticing that abuse. To do this, call:

Iowa Department of Human Services - 800-362-2178

Child in imminent danger -
Call 911 and report child abuse

It is good medical practice to recommend that other children in the care of an alleged perpetrator be evaluated for possible child abuse and neglect. You will find more detailed information on the legal aspects of child abuse in the summer 2003 issue of this newsletter.

Child protection resources

For assistance in the diagnosis and care of abused children, you

can contact a child protection center near you:

Cedar Rapids

Child Protection Center, St. Luke's Hospital
319-369-7908

Davenport

Quad City Child and Family Medical Resource Center
563-421-7160

Des Moines

Regional Child Protection Center, Blank Children's Hospital
888-972-4453, 515-241-4311

Iowa City

Child Assessment Clinic, University of Iowa Hospitals and Clinics
319-353-6128

Sioux City:

Child Advocacy Center, Mercy Hospital
800-582-0684, 712-279-2548



References

Heger, Astrid H. et al. (eds). Evaluation of the Sexually Abused Child, 2000.

Helfer, ME at al. (eds). The Battered Child, 1997.

Ludwig, S and Reece, RM (eds). Child Abuse: Medical Diagnosis and Management, 2001.

Oral, Resmiye. Intentional Head Trauma In Infants: Shaken Baby Syndrome. Virtual Children's Hospital, <http://www.vh.org/pediatric/provider/pediatrics/shakenimpactsyndrome/>

ADDITIONAL RESOURCES ON CHILD ABUSE

EPSDT Care for Kids Newsletter

Summer 2003

- Child sexual abuse and the primary care provider, K. Opdebeeck, MD. Physical indicators of abuse, forensic interview process
- Legal issues: Child sexual abuse and the primary care provider, C. Corken, Assistant Dubuque County Attorney. Documenting abuse, mandatory reporting, confidentiality, liability
- Who are Iowa's mandatory child abuse reporters?
- Training and education for professionals who deal with child sexual abuse
- Talking with children about sexual abuse: A guide for health care providers

Winter 2003

- Child abuse in Iowa, B. Harre, MD. Preventing abuse, services for abusive families, advocating for children in Iowa
- Sexual abuse and children with disabilities, B. Saboe, RN, MSN
- Factors that place children and families at risk for abuse
- Iowa information and referral resources on child abuse

Featured articles from Iowa's

EPSDT Care for Kids Newsletter, 1994 to 2003

1996-2003 issues are available online at w.medicine.uiowa.edu/uhs/EPSDT/index.cfm.

As we celebrate ten years of the *EPSDT Care for Kids Newsletter*, we would like to thank the many caring professionals who gave so freely of their time and expertise through the articles below.

Fall 2003 [This issue]

Summer 2003

- ◆ Child sexual abuse and the primary care provider, K. Opdebeeck
- ◆ Legal issues: Child sexual abuse, C. Corken
- ◆ Iowa's mandatory child abuse reporters
- ◆ Training resources: Child sexual abuse
- ◆ Talking with children about sexual abuse

Winter 2003

- ◆ Child abuse in Iowa, B. Harre
- ◆ Sexual abuse and children with disabilities, B. Saboe
- ◆ Factors that place children and families at risk for abuse
- ◆ Iowa information and referral resources on child abuse

Fall 2002

- ◆ Depression in children and adolescents, C. Boykin, D. Harper
- ◆ A checklist: Identifying childhood depression
- ◆ Iowa mental health resources for children and families

Summer 2002

- ◆ Health and Cultural Competency in Latino Communities, M. Yehieli, M. Msengi, J. Ogah
- ◆ Complementary and Alternative Medicine: Herbal Remedies that Pose a Risk, J. Murhammer
- ◆ Resources for Hispanic and Latino Families in Iowa

Winter 2002

- ◆ Childhood obesity, M. Tansey
- ◆ Breastfeeding and the primary care provider, C. Dungy
- ◆ Disaster preparedness and people with special needs
- ◆ Nutrition and WIC: Helping to build a healthier Iowa
- ◆ Smallpox vaccination in the 21st century

Fall 2001

- ◆ Well-child care for the child with disabilities, D. Van Dyke
- ◆ Results of lead testing for Iowa children, B. McPartland, R. Gergely
- ◆ Lead poisoning: Myths that place our children at risk

- ◆ Resources for well-child care of children with disabilities
- ◆ Required lead assessment protects Iowa's children

Spring 2001

- ◆ Developmental assessment: What is it? A. Healy
- ◆ Identifying infants at risk for hearing loss, L. Holte
- ◆ Statewide planning: The medical home model, R. Anderson
- ◆ Iowa's Early ACCESS program
- ◆ Pneumococcal immunization, E. Link

Winter 2001

- ◆ EPSDT Care for Kids screenings: Children 0-24 months
- ◆ EPSDT screening components
- ◆ EPSDT Care for Kids in Iowa 1999, S. Nadolsky
- ◆ Accurate measurements provide crucial information
- ◆ Recommended schedule of childhood vaccinations

Fall 2000

- ◆ Family planning services for Iowans from diverse cultures, S. Kahler, K. Leeper
- ◆ Promoting healthy adolescent sexual choices, M. Larew
- ◆ Lack of lead testing puts Iowa children at risk

Summer 2000

- ◆ Domestic violence and primary care, K. Mathews
- ◆ Parental substance abuse and its effects on children, R. Shaw
- ◆ Iowa referral resources for domestic violence
- ◆ Early childhood caries prevention in the medical home, R. Anderson
- ◆ Guidelines for health care providers who suspect a child or parent is being abused

Spring 2000

- ◆ The identification of postpartum depression, S. Stuart
- ◆ Treating postpartum depression, S. Stuart
- ◆ Evaluating maternal mental health
- ◆ Fact sheet on maternal depression

Fall 1999

- ◆ Dental screening and risk assessment for the very young child, M. Kanellis
- ◆ Dental health care and anticipatory guidance for children from birth to 3 years old
- ◆ Vaccines with and without thimerosal
- ◆ Agencies that provide EPSDT dental screening

Summer 1999

- ◆ Iowa's statewide immunization registry, J. Warming
- ◆ Recommended childhood immunization schedule, 1999
- ◆ Lead poisoning in Iowa's children, R. Gergely
- ◆ Childhood lead poisoning risk questionnaire
- ◆ Guidelines for identification and management of lead-poisoned children

Winter/Spring 1999

- ◆ The six-month exam, E. Link
- ◆ Health care issues in internationally adopted children, D. McBrien
- ◆ Iowa universal newborn hearing screening program
- ◆ The rotavirus vaccine, E. Link

Fall 1998

- ◆ Healthy and Well Kids in Iowa: HAWK-I, D. Van Dyke, D. McBrien
- ◆ More about Iowa HAWK-I, K. Leeper
- ◆ The new era of the varicella vaccine, C. Grose
- ◆ Chickenpox vaccination
- ◆ EPSDT Care for Kids 1997, S. Nadolsky

Spring/Summer 1998

- ◆ The effects of biology and environment on brain development, A. Sherbondy, D. Van Dyke
- ◆ Expanded health insurance for Iowa children through EPSDT and HAWK-I, K. Leeper
- ◆ Teratogens that can affect brain development
- ◆ How to help your child learn to love reading

Winter 1998

- ◆ Early stimulation and brain development, E. Link

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When You Suspect Abuse or Neglect

Work-up Guidelines

Health care providers can share this protocol with radiologists, and request that it be used whenever child abuse or neglect is suspected.

A PHYSICAL ABUSE work-up should include:

□ A skeletal survey:

- Humeri - antero-posterior (AP)
- Forearms - AP
- Hands - oblique, AP
- Femurs - AP
- Lower legs - AP
- Feet - AP
- Thorax - AP and lateral; oblique views to help detect rib fractures
- Pelvis - AP, including mid and lower lumbar spine
- Lumbar spine - lateral
- Cervical spine - lateral
- Skull - frontal and lateral; oblique views to determine extent of fractures

In suspicious spots of injury, repeat film with coning and restriction to the specific area.

Depending on what is learned, additional assessment may need to include:

□ **Bone scintigraphy** - The patient is injected with small amounts of radioactive tracers that are attracted to bone. A special camera takes pictures of the bones; the images show any damage.

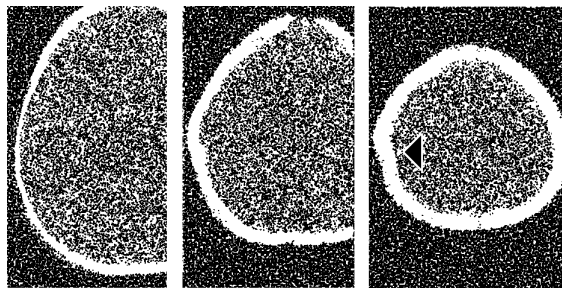
Use when suspicion is high for skeletal injury but initial skeletal survey is negative.

Or

Repeat skeletal survey in two weeks.

□ **CT scan of the head, including bone windows, without contrast**

Use when intra-cranial injury is suspected in acute presentation.



INFLECTED HEAD TRAUMA

- ◆ Is found in 12% of all physical abuse cases
 - ◆ Causes 80% of deaths from head trauma in children younger than two
- Virtual Children's Hospital

□ MRI of the head

Use when initial CT is negative but neurological findings are positive, or in cases presenting with subacute (>5-7 days) or chronic (>2-3 weeks) injury.

□ CT scan of the chest and abdomen with intravenous contrast

Use when trauma of the chest or stomach is suspected, or when child is comatose and has shaking impact injuries.

□ Complete blood count (CBC)

□ Platelet count (PLT)

□ Prothrombin time (PT)

□ Partial thromboplastin time (PTT)

□ Von Willebrand panel*

Use when bruises or intra-cranial or retinal bleeding are present.

**Von Willebrand disease, the most common inherited bleeding disorder, produces symptoms that include easy bruising, nosebleeds, prolonged bleeding following injury or surgery.*

□ Electrolytes

□ Liver function tests (AST, ALT, total bilirubin)

□ Amylase, lipase

□ Creatine phosphokinase (CPK)

□ Urinalysis and urine toxicology

Use when intracranial, abdominal, or muscular trauma are indicated or suspected and when intoxication or the presence of drugs is suspected.

□ Ophthalmology consult for funduscopy after pupil dilatation

Use when:

Intra-cranial injury, including shaken impact syndrome, is suspected.

Spiral fracture, metaphyseal fracture, or rib fracture are found in child younger than two.

Suspicious injury found in an infant younger than six months.

□ Swab and clean skin

Use when a fresh adult bite is present, if skin hasn't been washed. Clean with moistened sterile gauze; after air-drying, place gauze in a paper envelope and send it to CPS for saliva analysis.

If SEXUAL ABUSE is suspected,

use cultures (not DNA probes) to screen for:

Gonorrhea	Girls, prepubertal Girls, postpubertal Males	Throat, anus, vagina/vestibule Throat, anus, uterine cervix Throat, anus, urethra
Chlamydia (send on ice)	Girls, prepubertal Girls, postpubertal Males	Anus, vagina/vestibule Throat, anus, cervix Throat, anus, urethra
Herpes simplex virus (HSV)	All	Scraping of vesicles or ulcers for culturing
Syphilis Hepatitis B, C HIV	All	Blood sample for serology (after counseling the parents/child)
Trichomonas Bacterial vaginosis (clue cells)	All	Wet preparation of discharge
Pregnancy	Girls, postpubertal	Urine test Pap smear, if speculum exam is done
Sexual assault (acute)	All	Forensic evidence collection, using kit
Drug abuse	As indicated	Urine screening

You will find more detailed information on screening for child sexual abuse in the summer 2003 issue of this newsletter.

A NEGLECT work-up should include:

A skeletal survey (see page 5)	
Bone scintigraphy (see page 5)	Use when suspicion is high for skeletal injury, but initial skeletal survey is negative. Or Repeat skeletal survey in two weeks.
* MRI of the head	If indicated by the presence of unexplained neurological or structural findings

Depending on what is learned, additional assessment may need to include:

Complete blood count (CBC)	Serum protein and albumin
Platelet count (PLT)	Sweat test
Prothrombin time (PT)	Lead level
Partial thromboplastin time (PTT)	Urinalysis, urine culture, urine toxicology
Erythrocyte sedimentation rate (ESR)	Stool culture, ova and parasites including giardia; stool fat
Electrolytes	Nutrition consult
Liver function tests	Developmental assessment
BUN/creatinine	
Glucose	



EPSDT Care for Kids Newsletter, 1994 to 2003

1996-2003 issues are available online at w.medicine.uiowa.edu/uhs/EPST/index.cfm.

- ◆ The role of the Healthy Steps Specialist: Facilitating development, L. Nash
- ◆ Pertussis in the '90s, C. Grose
- ◆ Ways you can help your child's brain development
- ◆ Old myths and new knowledge: Brain development and your very young child
- ◆ Healthy Iowans 2010 is coming! R. Eckhof

Fall 1997

- ◆ Newborn hearing screening, G. Kahn
- ◆ Reasons for hearing screening,
- ◆ Iowa recommendations for EPSDT screenings
- ◆ Hearing impairment and its effect on speech and language, D. Downey
- ◆ How do I bill for hearing screening? S. Nadolsky

Summer 1997

- ◆ Iowa EPSDT Care for Kids 1996, S. Nadolsky
- ◆ Care coordinators link Iowa kids to health care, K. Leeper
- ◆ Helping your patients keep their appointments, K. Leeper
- ◆ Vaccines for Children (VFC) program update,
- ◆ OPV vs. IPV vaccine: A complex choice, C. Grose, MD
- ◆ Your EPSDT Care for Kids care coordinators

Spring 1997

- ◆ Pervasive development disorder, J. Piven, C. Plebst
- ◆ Severe behavior problems, W. Berg, D. Wacker
- ◆ Autistic disorder and PDD, NOS
- ◆ Functional assessment of behavior disorders

Winter 1997

- ◆ Biting: A common behavioral concern, L. Cooper
- ◆ Encopresis, V. Loening-Baucke
- ◆ Responding to problem behaviors
- ◆ Federal welfare reform affects children's SSI
- ◆ Pediatric behavior screening resources

Fall 1996

- ◆ The sports physical, D. Fick
- ◆ Adolescent athletes and substance abuse, M. Sims
- ◆ Timeout! Sports participation guidelines
- ◆ Resources on children and athletics

Summer 1996

- ◆ Adolescent health care, L. Duisdieker
- ◆ Crucial components of adolescent medical history
- ◆ Adolescent nutrition, S. Pohl
- ◆ Risk, taking behaviors and adolescent health, K. Overby
- ◆ Talking with your teenage patients
- ◆ The adolescent health care visit
- ◆ Varicella vaccine update, C. Grose
- ◆ More Iowa children are served by EPSDT, S. Nadolsky

Spring 1996

- ◆ Differential diagnosis: ADHD and learning disorders, L. Richman
- ◆ Assessment and referral for school-age children with behavior disorders, D. Dewdney
- ◆ Medications for attention deficit disorder, E. Link
- ◆ Markers: ADHD; language; memory; and visual, spatial disorders
- ◆ Iowa resources for children with ADHD, behavior disorders

Winter 1996

- ◆ The health of the school-age child, A. Sidler
- ◆ Violence prevention, J. Murph
- ◆ Preventing violence: The power of positive parenting
- ◆ Nutrition and the school-age child, J. Solberg
- ◆ Exercise, eating, and your child
- ◆ Healthy diet for the 6- to 10-year-old child

Fall 1995

- ◆ Guidelines for infant nutrition, J. Solberg
- ◆ Infant nutrition for children with special health care needs, J. Amundson
- ◆ Feeding your baby from birth to one year
- ◆ Non-nutritive sucking, A. Nowak

Summer 1995

- ◆ The physician's role in oral health care, M. Kanellis

- ◆ EPSDT Care for Kids dental screening: What's involved, A. Nowak
- ◆ Preventing nursing caries, M. Kanellis
- ◆ Anticipatory guidance and oral health: Age-appropriate topics
- ◆ New guidelines for fluoride supplementation

Spring 1995

- ◆ Developmental surveillance, A. Healy
- ◆ Developmental absolutes: Cues for need to assess development
- ◆ Risk factors, changing and unchanging
- ◆ Newborn hearing screening

Winter 1995

- ◆ Developmental assessment: What is it? Why should I do it? A. Healy
- ◆ Information resources: Children with disabilities and their families

Fall 1994

- ◆ The 15-month to 2-year examination, E. Link
- ◆ Immunizations: We must do better! L. Duisdieker
- ◆ Overcoming barriers to immunization, C. Danielson
- ◆ ACIP recommended immunization schedule
- ◆ Real and false contraindications for immunization
- ◆ The varicella vaccine, C. Grose

Summer 1994

- ◆ The 4- to 6-year examination, B. Cruikshank
- ◆ Lead screening in childhood, D. Weismann
- ◆ Parameters for growth and development; recommended screenings for children age 4 to 6
- ◆ Childhood lead poisoning risk questionnaire

Spring 1994

- ◆ EPSDT Care for Kids, C. Dungy
- ◆ Hepatitis B vaccine, C. Dungy
- ◆ Mental health: Screening infants from birth to 12 months of age, C. Whiteman
- ◆ How to: EPSDT Care for Kids screenings, C. Danielson
- ◆ Recommended EPSDT services, procedures; scheduling screenings
- ◆ Photoscreening for vision defects, C. Dungy

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If you have questions about **billing** related to EPSDT Care for Kids services, please call
Provider Services: **1-800-338-7909**

If you have questions about **clinical issues** and EPSDT Care for Kids services, please call
1-800-383-3826

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The *EPSDT Care for Kids Newsletter* is published three times a year, in print and online, as a joint effort of the Iowa Prevention of Disabilities Policy Council, the Iowa Department of Human Services, the Iowa Department of Public Health, and the Center for Disabilities and Development, which is nationally designated as Iowa's University Center for Excellence on Disabilities. The goal of this newsletter is to inform Iowa health care professionals about the EPSDT Care for Kids program, to encourage them to make use of this important resource, and to provide them with information about a wide range of developments in the field of health care.

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EPSDT Care for Kids Newsletter Reader Survey, Fall 2003

Dear EPSDT Care for Kids Newsletter Reader,

By answering the questions below, you can help shape the content in upcoming issues. Because we want this newsletter to be as useful and interesting as possible, we truly value your input. The survey is postage paid; just fold, tape, and mail. Thanks!

1. I usually read all of the EPSDT Care for Kids Newsletter.

Yes No

2. When it comes, I usually:

- Scan the headlines
- Read some of the articles
- Read it all
- Look for the handouts

3. After I read it, I often save it for future reference.

Yes No

4. Sometimes I only save the insert pages.

Yes No

5. I often share my copy with (check all that apply):

- Colleagues
- Other professionals
- Do not share it
- Office staff
- Patients and families
- Other, please explain: _____

6. I have visited the online version of the newsletter.

Yes No

7. I have printed out articles from the online version of the newsletter.

Yes No

8. I provide health care to [please indicate the populations you serve, and the approximate per cent of your practice that each group constitutes]:

- Children birth to age 5 years ____%
- Children age 6 to 11 years ____%
- Children age 12 to 21 years ____%
- Well-child care patients ____%

9. My profession is [please check all that apply]:

- Family physician
- Health care office manager
- Nurse
- Nurse practitioner
- Nutritionist
- Pediatrician
- Physician assistant
- Psychologist
- Public health nurse
- School nurse
- Social worker
- Other, please explain:

10. Topics I would like to see covered in future issues of this newsletter [please list]:

11. Comments or suggestions?

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Business Reply Set-up

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