

Assessments & Clinic Visits for Pediatric Care in Down syndrome

Organized by Developmental Stage

Patient Information

First name: _____ Personal Health Number: _____ Phone: _____
Last name: _____ Date of birth: _____ Age: _____ Email: _____

Notes

Reason for visit

Presenting problem

Physical examination

Genetic testing

Blood test

Heart

Hearing and vision

Thyroid

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Notes	
Stomach or bowel problems	
Respiratory issues and infections	
Developmental services	
Counselling	
Resources	

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Notes	
Additional notes	

Next Steps:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Physician Name: _____

Address: _____

Phone: _____

Email: _____

Fax: _____

Physician Signature: _____

Date: _____