

# Ohio DDD Internal Medicine

## Consultative Examination Guidelines

### Part VIII: Pediatric Consultative Examinations

## General Examination/Report Requirements

### Introduction and Required Components

Make sure the report - through its thoroughness and presentation and interpretation of evidence - demonstrates that a genuine effort has been made to identify all ophthalmological/optometric diagnoses and probable diagnoses, as well as formulate a carefully thought-out assessment of current functional status ("Medical Source Statement").

Make sure that the report documents the positive elements of the medical history and physical examination, as well as the negative elements. This is crucial because DDD cannot accept that an element of the history or physical examination was negative or normal unless it was explicitly stated to be negative or normal.

Make sure that all of the following requirements are met and documented in the report narrative using appropriate headings:

- A. Identify the Child
- B. List All Chief Complaints
- C. Elaborate on Each Complaint in the History of Present Illness
- D. Document Birth and Early Medical History
- E. Detail Developmental Milestones
- F. Document Pertinent Elements of Medical, Family and Social Histories and Medications
- G. Conduct a Thorough Review of Systems
- H. Measure Vital Signs
- I. Describe Child's General Appearance and Presentation
- J. Examine the Head, Eyes, Ears and Throat
- K. Examine the Neck
- L. Examine the Lungs
- M. Examine the Heart
- N. Examine the Abdomen
- O. Examine the Back and Spine
- P. Examine the Extremities
- Q. Perform a Neurological Examination
- R. Examine the Skin
- S. Review Medical Records from DDD
- T. List All Diagnostic Impressions
- U. Describe Functional Abilities in Several Domains
- V. Proofread
- W. Signature

### What If a Report is Inadequate?

If a report contains errors, DDD will need you to prepare an addendum that contains corrections or clarifying information. *Note: You are not paid for drafting addenda.*

If a report is missing important historical information or elements of the physical examination, DDD will need you to prepare an addendum and, in some cases, will require you to reexamine the child in your office at your own expense.

DDD understands that in some cases a child may be uncooperative. Document this in your report.

### Thoroughness and Time Spent During History and Physical

DDD does not want you to rush through these important examinations, which are distinct from your regular examinations in the course of medical practice. Sometimes a consultative examination is the only medical evidence DDD will receive, making it vital to the determination process.

You need not create a therapeutic relationship during a consultative examination, but do allow enough time so that some degree of rapport can be developed between examiner and examinee. Allow ample time for the child and/or parent/guardian to state all of his or her complaints and symptoms and to answer all of the questions with minimal interruptions from the examiner. This may take about an hour, but SSA requires that the history and physical (not including the writing and dictating of the report) must take 30 minutes or more.

Avoid excessively brief examinations. Important elements of the history or physical could be omitted during a cursory history and physical, which could result in the consultant having to complete a request for a clarifying addendum or even reexamine the claimant at the consultant's own expense. SSA requires that all claimant complaints be investigated, and one of the most common complaints is that an examination was too brief.

## Who Is Permitted to Perform Various Parts of the Examination?

DDD realizes that a physician is not needed to weigh, measure height, take blood pressure and pulse, or even measure visual acuity; however, SSA has published criteria that specify who can and who cannot do various aspects of the history, physical examination and ancillary testing.

The Green Book states: "The medical source chosen may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse, etc.) must meet appropriate licensing or certification requirements of the State."

DDD has no problem with some elements of the examination or testing performed by appropriate support staff, which would include licensed and certified physician extenders like physician assistants and nurse practitioners. Except for these "substitutions," DDD expects that the physician personally perform all of the following:

- Take the history
- Examine the child
- Interpret test results

## Professionalism and Complaints

DDD follows a formal procedure when a complaint is received. Common complaints in the past, in addition to allegations of an excessively brief examination encounter, have included that the consultant:

- Was rude
- Asked questions too quickly
- Did not give the claimant enough time to answer the questions
- Was rough when testing range of motion
- Had a poor bedside manner

If any complaint is received, DDD will write you, request a written response to the child's allegations and evaluate your response.

If a consultant receives multiple complaints, DDD will investigate and may cease to do business with that consultant.

You must be sincere and professional in all of your encounters with young claimants.

## Routine Review of Consultative Examination Quality

A statistical sample of reports is reviewed weekly by DDD's Chief Medical Consultant. When a report is found to be unsatisfactory, a letter is sent to the consultant, who must then submit a clarifying addendum. DDD monitors reports that deviate from SSA and DDD standards; however, most consultants regularly meet or exceed examination/report standards. When DDD does find poor quality reports, with no improvement in response to constructive criticism, the agency may cease to do business with a consultant.

## Definite and Probable Diagnoses: Dealing with Uncertainty

The primary reason DDD needs your services through a consultative examination is that the agency has received little or no medical evidence from a claimant's treating sources. This is usually because the treating sources have not responded to medical records requests or the child does not have a treating source. As a result, when you see a young claimant, you may not have other medical data that would assist you in definitively diagnosing any impairments or conditions the child may have.

Because of the lack of abundant medical testing and other data, you may not have enough information to make one or more definitive diagnoses on the basis of a one-time history and physical examination. It is acceptable to mention probable diagnoses.

## Voucher Information

Read all of the voucher information so that you complete what is requested. On some occasions, there are special instructions about specific elements of the history or physical upon which DDD would like you to focus and comment.

## Conducting Tests that Have Not Been Ordered

In the past, some consultants - on their own - have decided that an unordered test would be helpful and have gone on to perform the test. **This must not be done.** Payment will not be rendered for testing that is not preapproved and ordered on the voucher.

## How to Add a Test

If you do think it would be beneficial to add a test, such as Denver Developmental Survey or blood test, call DDD to discuss it. Sometimes, the agency will approve the added test. In this case, you will be paid for it, but **only** if you follow proper procedures and get approval in advance.

## Non-English-Speaking Children

For non-English-speaking children, the history must be obtained from family members present during the exam or from an interpreter contracted by DDD. Report communication difficulties whether due to:

- Language barrier
- Difficulty hearing
- Difficulty speaking
- Difficulty seeing
- Cognitive impairment
- Mental illness
- Other

## Specific Examination/Report Requirements

### Identify the Child

Confirm the child's identity with the parent/guardian attending the appointment.

### List All Chief Complaints

- Give claimant ample time to name complaints.
- Report from whom you obtained the medical history.
- Record whether you believe the child or other informant was reliable in presenting the history.

### Elaborate on Each Complaint in the History of Present Illness

- Elaborate fully on each symptom and specific illness stated as a chief complaint.
- Record when each symptom and/or disorder began.
- Explain how each disorder was diagnosed.
- Describe the severity of each symptom and/or specific disorder onset and how the severity has changed or progressed.
- Document any treatments, surgeries or procedures and how successful they have been.
- Note the presence of any known genetic defects or congenital anomalies or syndromes.
- If of age, describe impact of illness, disease or impairment on school attendance
- For children under 5, describe preschool and daycare behavior.
- Note whether an independent educational plan (IEP) or "504" is used in the school setting.
- Note any accommodations used in the school setting.
- Describe usual daily activities, including self-care; communicative abilities; social behavior with siblings, peers and adults; details of any problems and/or need for special assistance; ability to concentrate and persist in activities and maintain an adequate pace.
- Note the prescription of, or use of glasses, contacts or hearing aids.

- Note any assistive devices, appliances, ambulatory aids or technology used by the child, and the positive and negative effects (i.e., difficulty maintaining social interactions due to the presence of an assistive device.)
- Document frequency and severity data for episodic illnesses such as asthma and epilepsy (i.e., describe exacerbations or seizures in detail, what testing was done, test results, whether emergency department care or hospitalization was required, treatment, results of treatment and the frequency and dates of exacerbations/seizures and emergency department visits and hospitalizations.
- Note attendance or residence in highly structured or highly supportive environments, institutions or settings and any improvements.

### Document Birth and Early Medical History

List all of the following:

- Estimated gestational age
- Exact length at birth
- Exact weight at birth
- Maternal diseases or difficulties associated with the pregnancy
- Complications or difficulties with labor or delivery
- Deviations from normal growth
- Episodes of failure to thrive
- Delays in development
- Whether the child required management in the neonatal intensive care unit. If so, for how long and for what reasons? If mechanical ventilation was required, and if so, for how long? List any medications the child was sent home on from the hospital. List any monitors the child was sent home on from the hospital. Mention what type of follow up was recommended for the child.

### Detail Developmental Milestones

Describe developmental milestone accomplishments in detail, including the following:

- Gross motor (i.e., rolled over, sat up, stood up, walked, climbed stairs)
- Fine motor (i.e., held a toy or rattle, transferred objects, made a good pincer grasp, colored, wrote, scribbled)
- Language (i.e., smiled at times, laughed, said "Mama" or "Dadda", put two words together, put three words together, spoke in sentences, followed simple commands, followed two-step commands)
- Sociocultural (i.e., stranger fear, played pat-a-cake, took turns, played interactive games, gets dressed with help, gets dressed on own, is toilet trained)

## Document Pertinent Elements of Medical, Family and Social Histories and Medications

- List significant traumas.
- List surgeries and significant procedures.
- List significant infections such as meningitis and encephalitis.
- If present, list familial and genetic diseases in parents, siblings, and other relatives.
- List medications.
- List whether the following have been used and the extent of use (i.e., pack years, etc.):
  - » Tobacco (smoking)
  - » Tobacco (smokeless)
  - » Alcohol
  - » Illicit drugs

## Conduct a Thorough Review of Systems

- Record the positive results.
- Record the negative results. DDD cannot assume a symptom was absent if not explicitly stated.

## Measure Vital Signs

Report each of the following:

- Measured height without shoes (or length without shoes if the child is under 2)
- Height or length percentile (include growth chart if possible)
- Measured weight without shoes
- Weight percentile (include growth chart if possible)
- Head circumference if the child is under 3 or has a neurological or mental impairment
- Head circumference percentile
- Tanner stage
- Sitting blood pressure
- Sitting pulse
- Sitting respiratory rate
- Oral temperature if you believe the child is febrile.

## Describe Child's General Appearance and Presentation

- Describe the salient features of your first impression of the child in detail.
- Especially important are observations of:
  - » Obvious vision or hearing problems
  - » Facial dysmorphism
  - » Skeletal anomalies
  - » Other congenital anomalies
  - » Physical evidence indicating side effects of medication

- Also, note the following aspects of the child's appearance and presentation:

- » Behavior and attention span
- » How the child relates to and interacts with the examiner and the person who brought the child to the exam
- » Affect (Is it appropriate?)
- » Ability to hear and understand conversational speech
- » Speech (For a child up to 3 years of age, are the quantity and quality of sounds produced, both spontaneously and on imitation, age-appropriate? For a child 3 years of age and older, can the child be understood?)
- » Receptive language (Is the child's understanding of what is said to him/her age-appropriate in terms of vocabulary, content, etc.? (I.e., one-step directions, then two- and three-step directions?))
- » Expressive language (Is the child's production of language age-appropriate? (I.e., use of single words, then phrases, then sentences?))
- » Communicative ability (Can the child - of any age - express different communicative intents (i.e., requests objects by age-appropriate nonverbal or verbal means), and engage in age-appropriate communicative behaviors (i.e., turn-taking, establishing and maintaining a topic?))
- » Note whether dexterity and mobility are normal or impaired.

## Examine the Head, Eyes, Ears and Throat

- As noted under *Describe Child's General Appearance and Presentation*, note any head deformities, facial abnormalities or congenital anomalies.
- Formally assess visual acuity if possible. For younger children, note ocular tracking and ability to see as reflected by in-office behaviors.
- Check for the red reflex.
- Note conjunctival pallor, if present.
- Note the color of the sclera.
- Assess pupil reactivity.
- Test extraocular muscle function and note strabismus, if present.
- Assess ear canal patency and tympanic membrane integrity and appearance. Note the ability to hear and understand conversational speech. For younger children, note ability to track sound and ability to hear by in-office behaviors.
- Estimate the percentage of speech that is intelligible.

## Examine the Neck

Check for the following:

- Masses
- Deformities

## Examine the Lungs

Record any of these findings, if present:

- Chest deformity
- Diminished intensity (loudness) of breath sounds
- Pursed-lip breathing
- Tripod sitting
- "Barrel chest"
- Prolonged expiration phase of respirations
- Wheezes
- Crackles
- Labored breathing
- Cyanosis

## Examine the Heart

Record any of the findings, if present:

- Lateral displacement of the apical impulse on palpation
- Diffuse size of the apical impulse on palpation
- S3
- S4
- Murmurs, especially those of aortic or mitral stenosis or regurgitation.
- Record volume/intensity of peripheral pulses under "Examine the Extremities"

## Examine the Abdomen

Record any of these findings, if present:

- Ascites or "probable" ascites
- Palpable spleen
- Palpable masses
- Incisional hernias or open wounds
- Ventral hernias
- Inguinal hernias
- Palpable liver edge
- Abdominal wall collateral veins

## Observe and Examine the Back and Spine

Record any of the following findings, if present:

- Kyphosis
- Scoliosis
- Spina bifida or related abnormalities
- Paraspinal muscle spasm
- Paraspinal tenderness
- Sacroiliac joint tenderness
- Vertebral tenderness
- Listing of the lower back that makes one hip appear higher than the other
- Surgical scars

## Examine the Extremities

Focus the extremity exam on nine major areas:

1. Note any deformities or congenital anomalies.
2. Assess the approximate ranges of motion of the major (or symptomatic) joints.
3. Observe and palpate painful joints, joints with decreased range of motion and joints that appear grossly abnormal.

» Record any of the following joint findings, if present:

- *Bony enlargement*
- *Swelling or effusion*
- *Synovial thickening*
- *Warmth*
- *Erythema*
- *Tenderness*
- *Pain with range of motion maneuvers*
- *Deformities, such as ulnar deviation, or varus or valgus deformities of the knee*
- *Contractures*
- *Ligamentous laxity*
- *Crepitus*

4. Observe gait in detail.

» A detailed gait description is always needed if the child:

- *Has a visible limp or other abnormality of gait*
- *Alleges trouble walking or maintaining balance*
- *Has had a stroke or has another neuromuscular condition*
- *Has pain, decreased range of motion or an abnormality on examination of the:*
  - *Foot/ankle*
  - *Knee*
  - *Hip*
  - *Spine*

- » A detailed gait description includes all of the following:
    - *Description of exactly what you observe when the child walks or attempts to walk (see Appendix A for Select Abnormalities of Gait).*
    - *If the child uses a hand-held assistive device, if safe to do so, observe the child attempting to walk without the assistive device.*
    - *If the child uses a hand-held assistive device, decide whether it is necessary (obligatory) to allow ambulation in each of these circumstances:*
      - *Short distances on level surfaces*
      - *Long distances on level surfaces*
      - *Short distances on uneven surfaces*
      - *Long distances on uneven surfaces*
    - *Is the child a fall risk?*
5. Observe hand function in detail.
- » If age appropriate, remark whether the child can:
    - *Open a door*
    - *Open a jar*
    - *Pick up keys*
    - *Pick up a coin*
    - *Write*
    - *Button*
    - *Unbutton*
    - *Zip*
    - *Unzip*
  - » Describe the child's ability to:
    - *Grasp (grabbing, as in a hand shake)*
    - *Manipulate (handle)*
    - *Pinch (between the thumb and index finger)*
    - *Finely manipulate (rely on finger functioning as in typing)*
6. Observe limb bulk and symmetry for atrophy or differences in the sizes of the opposite extremities.
- » Measure the circumference of the forearms, arms, thighs, and legs if there is any suspicion of atrophy or asymmetry due to swelling/edema.
7. Observe the feet and ankles without socks and shoes.
- » Record any of these findings, if present:
    - *Edema (graded trace through 4+)*
    - *Lymphedema (usually the foot is swollen in addition to the ankle)*
    - *Foot or ankle or leg ulcers (if present, note location, depth, diameter, and appearance)*
8. Palpate peripheral pulses
- » Grade pulses "not palpable" through 4+.
9. In amputations, observe the status of the stump.
- » If a child has a prosthesis, describe ambulation with it in place.
  - » If a child does not have a prosthesis, describe ambulation (if this can be safely done).
- Perform a Neurological Examination**
- Perform a comprehensive neurological examination that must include each of the following eleven elements, though some elements have been described in other sections:
1. Describe general appearance and presentation (*see Describe Child's General Appearance and Presentation*).
  2. Examine cranial nerve function, including:
    - » Pupillary responses (III)
    - » Extraocular muscle movements (III, IV, VI)
    - » Visual acuity (II) [*see Examine the Head, eyes, ears, and throat*]
    - » Facial sensation (V)
    - » Facial symmetry (VII)
    - » Hearing and understanding of conversational speech (VIII)
    - » Gag reflex (IX)
    - » Shoulder shrug (XI)
    - » Tongue extension (XII)
  3. If indicated, perform funduscopic examination looking particularly for optic atrophy and papilledema.
  4. Observe gait in detail (*see Examine the Extremities*).
  5. Describe hand function in detail (*see Examine the Extremities*).

6. Examine motor strength in all major muscle groups graded as 0 through 5, where 5 is normal.

- » Attempt to elicit Babinski's sign.
- » Conduct motor strength proxy tests including:
  - *Ability to rise from the seated position without using hands*
  - *Ability to mount the examination table*
  - *Ability to dismount the examination table*
  - *Toe-walking*
  - *Heel-walking*
  - *Pronator drift*
- » Record any of the following findings, if present:
  - *Clonus*
  - *Increased muscle tone*
  - *Muscle hypertrophy*
  - *Decreased muscle tone*
  - *Spasticity*
  - *Flaccidity*
  - *Rigidity*

7. Observe any muscular atrophy and measure the circumference of the forearms, arms, thighs, and legs if there is any suspicion of it (*see Examine the Extremities*).

8. Elicit deep tendon reflexes (see following) and record results for each reflex on each side:

- » Brachioradialis
- » Biceps
- » Triceps
- » Knee
- » Ankle

9. Test each of the following sensory modalities:

- » Light touch
- » Pain sensation (pin prick)
- » Proprioception (great toe positioning)
- » Vibratory sensation

10. Test cerebellar function by doing the following:

- » Assessing gait for ataxia or unsteadiness (see above)
- » Finger-to-nose test
- » Heel-to-shin test
- » Rapid alternating movements
- » Romberg Test with eyes open and with eyes closed

11. Observe and report any abnormal movements such as:

- » Tremor
- » "Pill-rolling"
- » Tics
- » Chorea
- » Athetosis
- » Torticollis
- » Fasciculations

### Examine the Skin

- Describe in detail any of the following findings, if present:
  - » Foot or leg ulcers
  - » Surgical wounds that are not completely healed
  - » Open wounds of any kind
  - » Amputee stump abnormalities
  - » Rashes
  - » Abnormal skin findings such as sclerodactyly of scleroderma
  - » Finger tip ulcers as in scleroderma or lupus
  - » Cutaneous findings of Raynaud's phenomenon
  - » Gangrenous portions of the feet or elsewhere
  - » Healed surgical scars
- With rashes, DDD needs to know if there is involvement of these crucial areas:
  - » Feet
  - » Hands
  - » Inguinal region
  - » Perineal and perianal regions
  - » Axillae

### Review Medical Records from DDD

- If DDD has medical records on the claimant, the agency will send you some of the most pertinent records.
- Incorporate these results, if pertinent, in your ophthalmological/optometric diagnostic impressions (*see List All Diagnostic Impressions*) and your Functional Assessment (*see Provide a Functional Statement ("Medical Source Statement")*).

### List All Diagnostic Impressions

- This is a key element of the consultative examination and report.
- Include confirmed diagnoses and "probable" diagnoses (*see General Examination/Report Requirements and Definite and Probable Diagnoses: Dealing with Uncertainty*).

## Provide a Functional Statement (“Medical Source Statement”)

- This is an “educated estimate” of ability of the child’s ability to function.
- DDD realizes that you do not have the availability of every useful test to help you; that is why it is described as an “educated estimate.”
- Use all of the data you do have, including the history, examination results, any X-rays or other tests done in your office (if applicable), and any medical records sent to you by us.
- What is most important is that you do a reasonable and realistic assessment of function based on everything you know or have discovered about the child’s medical illnesses and functional status.
- Include the effects of symptoms if there are plausible underlying medical conditions that could cause them. For example, if a child has an underlying disease or disorder that can cause pain and the child complains of pain, this should be taken into consideration fully in determining functional status.
- Include a description of all functional limitations. These should be based on age-appropriate expectations. What is needed is a specific description of how the child’s impairments limit his or her function compared to age-appropriate expectations. Using estimated percentile ratings is helpful. For example, a child may be described as meeting 50% of age-appropriate motor skills, and 75 percent of age-appropriate fine motor skills.
- SSA’s specified domains of function are detailed in Appendix B. Some of the major functionalities by age are listed below:

» Infants less than 1 year of age:

- *Communication*
- *Cognition*
- *Gross motor*
- *Fine motor*
- *Responsiveness to stimuli*
- *Social interaction*

» Children ages 1 to 3 years:

- *Communication*
- *Cognition*
- *Gross motor*
- *Fine motor*
- *Behavior*
- *Concentration*
- *Social skills*

» Children older than 3 years:

- *Communication*
- *Cognition*
- *Gross motor*
- *Fine motor*
- *Behavior*
- *Concentration*
- *Social skills*
- *Persistence*
- *Pace*

## 1151 Form

- For some appeals, an administrative law judge will request an *1151 Form (Part II - Appendix D)*, which should be included in your packet. If it is requested on the voucher but not in the packet, *contact DDD*.
- You are not expected to fill out the portions not related to otolaryngological issues; you must complete the relevant part of page 4, the question about noise exposure on page 5 and sign the form.
- An extra fee is paid for completion of a requested *1151 Form*. The form is self-explanatory.
- The same principles stated under *Provide a Functional Statement (“Medical Source Statement”)* of the claimant’s ability to see should be used in completing the 1151. A copy of an 1151 form can be found in Appendix D.

## Proofread

## Signature

Sign the report personally. Stamps, electronic signatures or signatures by persons other than the consultative physician are not permitted.

## Part VIII Appendices

- A. Common Gait Abnormalities (see Part II - Appendix C)
- B. Pediatric Domains of Function Specified by SSA

### Part VIII - Appendix B: Pediatric Domains of Function Specified by SSA

Social Security has determined that some impairments of certain severity are “automatically” disabling. These are called Listings and include conditions such as deafness, blindness, advanced cystic fibrosis, uncontrolled seizures. For children who do not meet Listings, SSA specifies that the assessment of a child for disability include the following six domains:

1. Acquiring and using information
2. Attending and completing tasks
3. Interacting and relating with others
4. Moving about and manipulating objects
5. Caring for oneself
6. Health and physical well-being

SSA uses these domains for disability applicants up to age 18. The domains are each rated on a scale ranging from “No limitation” through “Less than Marked” and “Marked” up to “Extreme.” Age-level norms are considered when rating a child’s functioning in a domain. Disability is found when a child has marked limitations in two domains or an extreme limitation in one domain. An example of a marked limitation is IQ score of 60 to 70 with commensurate functioning. An example of an extreme limitation would be a child under age 3 with motor function of 50 percent or less of normal (compared to same-age peers).

In the first domain, **Acquiring and Using Information**, SSA considers how well the child learns and applies information. Learning and thinking begins at birth as the infant explores the world through sight, sound, taste, touch and smell. Infant activities lead to the acquiring of concepts and language, which later allows for more advanced learning. Thinking is the application or use of information learned. It involves being able to perceive relationships, reason, and make logical choices. People think in different ways. When you think in pictures, you may solve a problem by watching and imitating what another person does. When you think in words, you may solve a problem by using language to talk your way through it. Children should be able to use language to think, to understand others, to ask questions, and to express themselves.

The domain of **Attending and Completing Tasks** considers how well the child focuses and maintains attention, and how well he/she begins, carries through, and completes activities, including the pace of performance and the ease of dealing with changing activities. Attention involves the ability to filter out distractions and to remain focused on an activity or task at a consistent level of performance. Adequate attention permits a child to think and reflect before starting or stopping an activity. In other words, the child can look ahead and predict possible outcomes of courses of actions. Focusing attention allows tasks to be conducted at an appropriate pace to finish within an appropriate timeframe.

**Interacting and Relating With Others** is a domain that considers how well the child initiates and sustains emotional connections with others, develops and uses the language of the community, cooperates with others, complies with rules, responds to criticism, and respects and takes care of the possessions of others. Interacting involves initiating and responding to exchanges with other people, for practical and social purposes. This domain covers speech intelligibility and fluency, and the ability to respond appropriately to a variety of emotional and behavioral cues. Relating to other people includes forming and sustaining relationships with family members and with age-appropriate friends. This domain also covers how the child responds to persons in authority, such as parents, teachers, bus drivers, coaches, and employers.

The domain of **Moving About and Manipulating Objects** considers gross and fine motor skills. For infants and very young children, limitations could be seen in areas such as rolling over or rising or pulling from a sitting to a standing position. Older children should have, among other things, normal abilities to sit, stand, walk, run, bend, kneel, stoop, crouch and crawl. This domain involves several kinds of actions:

- Using the upper and lower body to push, pull, lift, and carry objects
- Controlling shoulders, arms, and hands to hold and transfer objects
- Coordinating eyes and hands to manipulate small items.

These actions require varying degrees of strength, coordination, dexterity, pace and the physical ability to persist and sustain. This domain includes integration of sensory input and motor output, as well as the capacity to plan, remember, and execute controlled motor movements.

**Caring for Yourself** considers how well the child maintains a healthy emotional and physical state. This includes:

- Getting physical and emotional wants and needs met in appropriate ways
- Coping with stress and changes in the environment
- Taking care of one's own health, possessions and living area.

Caring for Yourself includes age-appropriate feeding, dressing, toileting and bathing, as well as displaying judgment about the consequences of actions. This domain covers the ability to identify and regulate feelings, thoughts, urges, and intentions. Caring for Yourself includes recognizing when one is ill, following recommended treatment, taking medication as prescribed, following safety rules, responding to circumstances in safe and appropriate ways, and knowing when to ask others for help.

In the sixth domain, **Health and Physical Well-Being**, SSA considers the cumulative physical effects of physical and/or mental impairments. This domain covers interference with a child's normal activities due to illness, as well as due to medications, therapies or other treatment (note that this does not include limitations considered under *Moving About and Manipulating Objects*). This domain addresses problems such as dizziness, shortness of breath, allergic reactions, recurrent infections, poor growth, and pain. Medications, such as those used for asthma or depression, chemotherapy, or multiple surgeries may have physical effects that limit normal activities. For episodic illnesses, such as asthma and epilepsy, the severity, frequency, and duration of exacerbations or occurrences are considered. This domain also considers the impact of intensive medical care in a medically fragile child.