Screen Date____________________

West Virginia Department of Health
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

12 Month Form

Name____________________ DOB____________ Age________ Sex: ☐ M ☐ F **Race/Ethnicity**____________

Weight ________ Length________ Weight for Length________ HC________ Pulse________ BP (*optional*)________ Resp________ Temp________ Pulse Ox (*optional*)________

Allergies ☐ NKDA ____________________

Current meds ☐ None ____________________

☐ Foster child ____________ ☐ Kinship placement____________ ☐ Child with special health care needs____________

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization____________ ☐ Other ____________

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** ____________

Parental history of postpartum depression ☐ Yes ☐ No

____

In utero substance exposure ☐ Yes ☐ No ____________

Maternal Hep C exposure ☐ Yes ☐ No ____________

High birth score ☐ Yes ☐ No ____________

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:____________

____

Psychosocial/Behavioral

What is your family's living situation?____________

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No ____________

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No ____________

Who do you contact for help and/or support?____________

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care____________

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)____________

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

Concerns and/or questions____________

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other____________

Baby Pediatric Symptom Checklist (BPSC)

****Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.***

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score ____________

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score ____________

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?
☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score ____________

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can protoimperative point (point to request an object) ☐ Child can imitate new gestures ☐ Child can look for hidden objects

Verbal Language (Expressive and Receptive) ☐ *Child can babble ☐ *Child can imitate vocalizations and sounds ☐ Child can use "Dada" or "Mama" specifically ☐ Child can use 1 word other than "Mama," "Dada," or personal name

Gross Motor ☐ Child can take first independent steps ☐ Child can stand without support

Fine Motor ☐ Child can drop an object in a cup ☐ Child can pick up small objects with 2 finger pincer grasp ☐ Child can pick up food and eat it

****Absence of these milestones = Autism Screen***

Concerns and/or questions____________

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No

Continue on page 2

Name______________________________ DOB____________________ Age__________ Sex: ☐ M ☐ F

Oral Health
Dental referral required at 12 months
Tooth eruption ☐ Yes ☐ No
Current oral health problems ____________________
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No ____________________

Nutrition/Sleep
☐ Breastfeeding - Frequency ____________________
☐ Bottle feeding - Amount__________ Frequency__________
☐ Formula ____________________
Plans for weaning____________________
☐ Milk ☐ Juice ☐ Water
☐ Has started solid foods ☐ Table foods ☐ Normal eating habits
☐ Vitamins
☐ Normal elimination____________________
☐ Normal sleeping patterns____________________

***Anemia Risk (Hemoglobin/Hematocrit)**
Hemoglobin/hematocrit required at 12 months

***Lead Risk**
Blood lead required at 12 months

***Tuberculosis Risk** ☐ Low risk ☐ High risk

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance ☐ N ☐ Abn ____________
Skin ☐ N ☐ Abn ____________
Neurological ☐ N ☐ Abn ____________
Reflexes ☐ N ☐ Abn ____________
Head ☐ N ☐ Abn ____________
Fontanelles ☐ N ☐ Abn ____________
Neck ☐ N ☐ Abn ____________
Eyes ☐ N ☐ Abn ____________
Red Reflex ☐ N ☐ Abn ____________
Ocular Alignment ☐ N ☐ Abn ____________
Ears ☐ N ☐ Abn ____________
Nose ☐ N ☐ Abn ____________
Oral Cavity/Throat ☐ N ☐ Abn ____________
Lung ☐ N ☐ Abn ____________
Heart ☐ N ☐ Abn ____________
Pulses ☐ N ☐ Abn ____________
Abdomen ☐ N ☐ Abn ____________
Genitalia ☐ N ☐ Abn ____________
Back ☐ N ☐ Abn ____________
Hips ☐ N ☐ Abn ____________
Extremities ☐ N ☐ Abn ____________

Signs of Abuse/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Establishing Routines, Feeding and Appetite Changes, Establishing a Dental Home, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

____

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(required at 12 months)*
☐ Blood lead *(required at 12 months) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other
____
____

Referrals
☐ Developmental ☐ **Dental** ☐ Blood lead $\geq$5ug/dl
☐ Other ____________________
____

☐ Birth to Three (BTT) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**

Medical Necessity
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.

Follow Up/Next Visit ☐ 15 months of age

☐ Other____________________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

____
Signature of Clinician/Title