Screen Date____________________

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

18 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 ____________

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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget____________

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____________

Does your child seem nervous or afraid?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?
☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?
☐ Not at all ☐ Somewhat ☐ Very much

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool____________

Results in child's record ☐ Yes ☐ No

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool____________

Results in child's record ☐ Yes ☐ No

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

Oral Health

Date of last dental visit____________

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

☐ Normal eating habits

☐ Vitamins

☐ Normal elimination____________

☐ Normal sleeping patterns____________

Hours of sleep each night?____________

Continue on page 2

Name_______________________ DOB_______________ Age__________ Sex: ☐ M ☐ F

***Anemia Risk (Hemoglobin/Hematocrit)**	☐ Low risk	☐ High risk
***Lead 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	________
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)*

Temperament, Development, Toilet Training, Behavior and Discipline, Communication and Social Development, Television Viewing and Digital Media, Healthy Nutrition, 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 *(if high risk)*
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other ________________________________

Referrals

☐ Developmental ☐ Dental
☐ 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 ☐ 24 months of age

☐ Other________________________________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

____
Signature of Clinician/Title