Screen Date_____

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

11, 12, 13 and 14 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement_____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

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

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 12 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 11 and 14 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about speech, learning, social and/or motor skills
_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Family Planning Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic screen
☐ **Family health history reviewed** _____
_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are parents/caregivers working outside home? ☐ Yes ☐ No
Child care/after school care _____
Grade in school_____
Favorite subject_____

Any problems_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor
☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes/Vaping ☐ *Chew ☐ Passive Smoke Risk
☐ *Alcohol use_____
☐ *Drug use (prescription or otherwise)_____
If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

(13 and 14 years)
Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No
Are you sexually active? ☐ Yes ☐ No
Method of contraception _____
Do you have children? ☐ Yes ☐ No _____
_____

Traumatic Stress Reactions/PCL-C
Positive screen = numbered responses 4 or greater
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)
Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Depression Screen/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If Positive see Periodicity Schedule for link to PHQ-9
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Little interest or pleasure in doing things: ☐ Not at all (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)
Feeling down, depressed, or hopeless: ☐ Not at all (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Continue on page 2

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Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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 ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals
- ☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
- ☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
- ☐ Frequent use of profane, vulgar, or curse words to household members
- ☐ Deliberate damage to home
- ☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
- ☐ Marked changes in moods that are generally intense and abrupt
- ☐ Friendships change to mostly substance users
- ☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Currently at risk of confinement because of frequent or serious violations of law
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Suicide Risk Screen

In the past few weeks, have you wished you were dead?
☐ Yes ☐ No
In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
Have you ever tried to kill yourself? ☐ Yes ☐ No

If patient answers Yes to any of the above, or refuses to answer, they are considered a positive screen. Ask the following acuity question:

Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
(Yes, imminent risk identified. Patient required a STAT safety/full mental health evaluation.)

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Dyslipidemia Risk** Fasting lipoprotein required once between 9 and 11 years	☐ Low risk	☐ High risk
***STI Risk**	☐ Low risk	☐ High risk
***HIV 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	_____
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	_____

If female:

LMP_____	☐ Regular	☐ Irregular
Bleeding	☐ Normal	☐ Heavy
Cramping	☐ No	☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

_____
_____
_____

Sudden Cardiac Arrest (SCA) Evaluation

- ☐ Fainted, passed out or had an unexplained seizure suddenly and without warning.
- ☐ Experienced exercise-related chest pain or shortness of breath.
- ☐ Had an immediate family member or distant relative die of heart problems or unexpected sudden death before age 50.
- ☐ Related to anyone with hypertrophic obstructive cardiomyopathy (HCM), Marfan syndrome, Arrhythmogenic cardiomyopathy (ACM), long QT syndrome (LQTS), short QT syndrome, BrS (baroreflex sensitivity) or Catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator.

(Positive response or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist.)

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

Social Determents of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child Visit ☐ Other Diagnosis

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ TB skin test *(if high risk)*
- ☐ Fasting lipoprotein (*once between 9 and 11 years and/or high risk)*
- ☐ STI test *(if sexually active and/or high risk)*
- ☐ HIV test *(if sexually active and/or high risk)*
- ☐ Hepatitis B Screen (HBsAG) *(if high risk)*
- ☐ Other _____

Referrals
See page 1, school requirements

☐ Pediatric Cardiologist *(based on SCA evaluation above)*
☐ Mental health evaluation

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 ☐ 12 years of age ☐ 13 years of age
☐ 14 years of age ☐ 15 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

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