Screen Date____________________

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

15, 16 and 17 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 ☐ N/A ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization______________ ☐ Other ______________

School Entry Requirements

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 15 years)*
R ______________ L ______________
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 15 and 17 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

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 living situation?______________
____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No ________
____
Are you still in school? ☐ Yes ☐ No Working? ☐ Yes ☐ No
What are your future plans?______________
____

What interests do you have outside of school and/or work? ________
____

☐ *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

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

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 your-self? ☐ 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 17 and 20 years*	☐ Low risk	☐ High risk
***STI Risk**	☐ Low risk	☐ High risk
***HIV Risk** *HIV test required once between 15 and **20** years*	☐ 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 Determinants of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Fasting lipoprotein (*once between 17 and 20 years and/or high risk)*
☐ STI test *(if sexually active and/or high risk)*
☐ HIV test *(once between 15 and **20** years, 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 evaulation

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 ☐ 16 years of age ☐ 17 years of age ☐ 18 years of age ☐ Other__________________

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature