

Screen Date _____

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

3 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 _____

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 _____

Vision Acuity Screen:

R _____ L _____ UTO (retest in 6 months)

Wears glasses? Yes No

Hearing Screen (Subjective screen required)

Do you think your child hears okay? Yes No

Wears hearing aids? Yes No

Developmental

Developmental Surveillance (✓ Check those that apply)

- Child can enter bathroom and urinate by himself/herself
- Child can put on coat, jacket or shirt by themselves
- Child can eat independently
- Child can engage in imaginative play
- Child can play in cooperation and share
- Child can use 3 word sentences
- Child can speak in words that are 75% understandable to strangers
- Child can tell you a story from a book or TV
- Child can compare things using words like bigger or shorter
- Child can understand simple prepositions, such as on or under
- Child can pedal a tricycle
- Child can climb on and off couch or chair
- Child can jump forward
- Child can draw a single circle
- Child can draw a person with head and 1 other body part
- Child can cut with child scissors

Concerns about child's speech, learning, or motor skills

Immunizations: Attach current immunization record

UTD Given, see immunization record Entered into WVSIIS

Referrals: Developmental

Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498

Dental Vision Hearing

Other _____

Children with Special HealthCare Needs (CSHCN)

1-800-642-9704

Women, Infants and Children (WIC) **1-304-558-0030**

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 _____

In utero substance exposure Yes No

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

Child care/after school care _____

Is your child in school? Yes No _____

Favorite thing about school _____

Any problems? _____

Activities outside school _____

Peer relationships/friends Good Okay Poor

Child exposed to Cigarettes E-Cigarettes/Vaping Alcohol

Drugs (prescription or otherwise) _____

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

Scary experience that your child cannot forget _____

Do you utilize a car/booster seat for your child? Yes No

Excessive television/video game/internet/cell phone use

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 _____

Continue on page 2



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>).

- Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- Often mean and nasty to other people and animals
- Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- Often plays alone even when there are opportunities for peer play, would rather be alone
- Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

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
- ***Lead Risk** Low risk High risk
- ***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 _____

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 _____

Possible Signs of Abuse/Neglect Yes No

Concerns and/or questions _____

Age Appropriate Health Education/Anticipatory

Guidance (Consult Bright Futures, Fourth Edition. For further information: <https://brightfutures.aap.org>)

Social Determinants of Health, Playing with Siblings and Peers, Encouraging Literacy Activities, Promoting Healthy Nutrition and Physical Activity, and Safety

Discussed Handouts Given

Plan of Care

Assessment

Well Child Other Diagnosis

Labs

- Hemoglobin/hematocrit (if high risk)
- Blood lead (if not completed at 12 and/or 24 months or high risk) (enter into WVSIIIS)
- TB skin test (if high risk)
- Hepatitis B Screen (HBsAG) (if high risk)
- Other _____

Referrals

See page 1, school requirements

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 4 years of age

Other _____

Screen has been reviewed and is complete

See page 1, school requirements for required signature

