Screen Date_____

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

2 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Child with special health care needs_____

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

Medical History

☐ Initial screen ☐ Periodic screen

Newborn metabolic screen ☐ NL ☐ Results in child's record
Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____
☐ Results in child's record

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

☐ **Family health history reviewed** _____
_____

Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family's living situation?_____
_____

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 plans? _____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Sever

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_____
_____
_____

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

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child smiles responsively ☐ Child makes sounds that let you know if he/she is happy
Verbal Language (Expressive and Receptive) ☐ Child makes short cooing sounds
Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position
Fine Motor ☐ Child can open and shut hands ☐ Child can briefly bring hands together
Concerns and/or questions_____
_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

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
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breast feeding; Frequency _____
☐ Bottle feeding; Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Normal sleeping patterns_____
☐ Place on back to sleep_____
☐ Sleeps 3 to 4 hours at a time_____
Concerns and/or questions_____
_____

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 ☐ Yes ☐ No

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health

- ☐ Living situation and food security
- ☐ Family support
- ☐ Child care

Parental/Family Health and Well-being

- ☐ Postpartum checkup
- ☐ Depression
- ☐ Sibling relationships

Infant Behavior and Development

- ☐ Parent –infant relationship
- ☐ Parent-infant communication
- ☐ Sleeping
- ☐ Media
- ☐ Playtime
- ☐ Fussiness

Nutrition and Feeding

- ☐ General guidance on feeding and delaying solid foods
- ☐ Hunger and satiety cues
- ☐ Breastfeeding guidance
- ☐ Formula-feeding guidance

Safety

- ☐ Car seat safety
- ☐ Safe sleep
- ☐ Safe home environment (burns, drowning, and falls)

☐ **Other**

_____

Questions/Concerns/Notes

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Immunizations

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

Labs_____

Referrals ☐ Maternal depression-**Help4WV.com/1-844-435-7498**
☐ Developmental
☐ Other _____

☐ Right from the Start (RFTS) **1-800-642-9704**
☐ 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**

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

Follow Up/Next Visit ☐ 4 months of age

☐ Other_____

☐ **Screen has been reviewed and is complete**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title