### Medical History
- Initial screen
- Periodic screen

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?

- 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 has ability to separate from parents/caregivers: Yes, No

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

### Developmental
- Developmental surveillance and screening completed with Standardized Screening Tool

- ASQ3
- Other tool

Results in child’s record: Yes, No

Concerns and/or questions:

### Risk Indicators (check those that apply)
- Child exposed to: Cigarettes, E-Cigarettes, Alcohol
- Drugs (prescription or otherwise)
- Access to firearm(s)/weapon(s)
- Are the firearm(s)/weapon(s) secured? 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
- Tooth eruption: Yes, No
- 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
- Juice
- Water
- Has started solid foods
- Table foods
- Normal eating habits
- Vitamins
- Normal elimination
- Normal sleeping patterns

### Physical Examination (N=Normal, Abn=Abnormal)
- General Appearance
- Skin
- Neurological
- Reflexes
- Head
- Fontanelles
- Neck
- Eyes
- Nose
- Red Reflex
- Ocular Alignment
- Ears
- Pulse Ox (optional)
- Heart
- Lung
- Abdomen
- Genitalia
- Back
- Hips
- Extremities

### Signs of Abuse
- Yes, No

Concerns and/or questions:

Continue on page 2
## Anticipatory Guidance

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

### Social Determinants of Health
- Intimate partner violence
- Family relationships and support

### Infant Behavior and Development
- Changing sleep pattern (sleep schedule)
- Developmental mobility and cognitive development
- Interactive learning and communication
- Media

### Discipline
- Parent expectations of child’s behavior

### Nutrition and Feeding
- Self-feeding, mealtime routines, transition to solid foods (table food introduction), cup drinking
- Plans for weaning

### Safety
- Car safety seats
- Heatstroke prevention
- Firearm safety
- Safe home environment (burns, poisoning, drowning, falls)
- Other

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### Plan of Care
- Assessment  
  - Well Child  
  - Other Diagnosis

#### Immunizations
- UTD  
  - Given, see immunization record  
  - Entered into WVSIS

#### Labs
- Blood lead (if high risk) (enter into WVSIS)
- Other

#### Referrals
- Developmental
- Other
- Right from the Start (RFTS) [1-800-642-9704](tel:1-800-642-9704)
- Birth to Three (BTT) [1-800-642-9704](tel:1-800-642-9704)
- Children with Special HealthCare Needs (CSHCN) [1-800-642-9704](tel:1-800-642-9704)
- Women, Infants and Children (WIC) [1-304-558-0030](tel: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](tel:1-800-642-9704) or [www.dhhr.wv.gov/healthcheck](http://www.dhhr.wv.gov/healthcheck)

### Follow Up/Next Visit
- 12 months of age
- Other

- Screen has been reviewed and is complete

### Please Print Name of Facility or Clinician


### Signature of Clinician/Title