West Virginia Department of Health and Human Resources  
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Health Check Program Preventive Health Screen  
Newborn to 1 Week Form

### Medical History

- **Gestational age**
- **Maternal labs**
- **Complications**
  - Birth history: NSVD, C-section, Breech, Yes, No
  - Birth weight:
  - Discharge weight:
  - Newborn metabolic screen: NL
  - Newborn bilirubin screen: NL
  - Newborn critical congenital heart disease pulse oximetry
  - Newborn hearing screen: Pass, Fail, Pending, Retest

- **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, Severe

- **What kind of stress?**

<table>
<thead>
<tr>
<th>Stress Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships (partner, family and/or friends)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School/work</td>
<td></td>
<td></td>
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<tr>
<td>Child care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
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<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence/abuse (physical, emotional and/or sexual)</td>
<td></td>
<td></td>
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<tr>
<td>Family member incarcerated</td>
<td></td>
<td></td>
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<tr>
<td>Lack of support/help</td>
<td></td>
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<tr>
<td>Financial/money</td>
<td></td>
<td></td>
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<tr>
<td>Emotional loss</td>
<td></td>
<td></td>
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<tr>
<td>Health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Developmental

- **Developmental Surveillance**
  - **Check those that apply**

### Social Language and Self-help

- **Check those that apply**

### Verbal Language

- **Check those that apply**

### Gross Motor

- **Check those that apply**

### Fine Motor

- **Check those that apply**

### Risk Indicators

- **Check those that apply**

### General Health

- **Check those that apply**

### Oral Health

- **Water source**

### Nutrition/Sleep

- **Breastfeeding - Frequency**

- **Bottle feeding - Amount**

- **Frequency**

### Other

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you think your child sees okay?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physical Examination

**Check those that apply**

- **Normal, Abnormal**

### Possible Signs of Abuse

**Check those that apply**

- **Yes**

### Continue on page 2

---

**Screen Date**

**DOB**

**Age**

**Sex**

**Weight**

**Height**

**Length**

**Weight for Length**

**HC**

**Pulse**

**BP (optional)**

**Resp**

**Temp**

**Pulse Ox (optional)**

**Allergies**

- **None**

**Current meds**

- **None**

**Foster child**

- **Yes**

**Child with special health care needs**

- **Yes**

**Accompanied by**

- **Parent**

- **Grandparent**

- **Foster parent**

- **Foster organization**

**Concerns and/or questions**

---

**General Appearance**

- **Normal, Abnormal**

**Skin**

- **Normal, Abnormal**

**Neurological**

- **Normal, Abnormal**

**Reflexes**

- **Normal, Abnormal**

**Head**

- **Normal, Abnormal**

**Fontanelles**

- **Normal, Abnormal**

**Neck**

- **Normal, Abnormal**

**Eyes**

- **Normal, Abnormal**

**Red Reflex**

- **Normal, Abnormal**

**Ears**

- **Normal, Abnormal**

**Nose**

- **Normal, Abnormal**

**Oral Cavity/Throat**

- **Normal, Abnormal**

**Lung**

- **Normal, Abnormal**

**Heart**

- **Normal, Abnormal**

**Pulses**

- **Normal, Abnormal**

**Abdomen**

- **Normal, Abnormal**

**Umbilical cord**

- **Normal, Abnormal**

**Genitalia**

- **Normal, Abnormal**

**Back**

- **Normal, Abnormal**

**Hips**

- **Normal, Abnormal**

**Extremities**

- **Normal, Abnormal**

**Jaundice**

- **Yes**

---

**Concerns and/or questions**

---

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**Continue on page 2**
<table>
<thead>
<tr>
<th><strong>Anticipatory Guidance</strong></th>
<th><strong>Questions/Concerns/Notes</strong></th>
<th><strong>Plan of Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(Consult Bright Futures, Fourth Edition for further information <a href="https://brightfutures.aap.org">https://brightfutures.aap.org</a>)</em></td>
<td></td>
<td><strong>Assessment</strong> □ Well Child □ Other Diagnosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Social Determinants of Health</strong></th>
<th></th>
<th><strong>Immunizations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Living situation and food security</td>
<td></td>
<td>□ UTD □ Given, see immunization record □ Entered into WVSIS</td>
</tr>
<tr>
<td>□ Environmental tobacco exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Intimate partner violence</td>
<td></td>
<td></td>
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<tr>
<td>□ Maternal alcohol and substance use</td>
<td></td>
<td></td>
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<tr>
<td>□ Family Support</td>
<td></td>
<td></td>
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<tr>
<td>□ Parent(s)-newborn relationship</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Parental/Family Health and Well-being</strong></th>
<th></th>
<th><strong>Labs</strong></th>
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</thead>
<tbody>
<tr>
<td>□ Maternal health and nutrition</td>
<td></td>
<td></td>
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<tr>
<td>□ Transitioning home</td>
<td></td>
<td></td>
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<tr>
<td>□ Sibling adjustments/relationships</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Newborn Behavior and Care</strong></th>
<th></th>
<th><strong>Referrals</strong> □ Developmental □ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Baby care (infant supplies, skin, and cord care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Illness prevention (hand washing, outings and sun protection)</td>
<td></td>
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<tr>
<td>□ Calming your baby</td>
<td></td>
<td></td>
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<tr>
<td>□ Early brain development (singing, talking and reading to child)</td>
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<tr>
<td>□ Emergency care</td>
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<table>
<thead>
<tr>
<th><strong>Nutrition and Feeding</strong></th>
<th></th>
<th><strong>Prior Authorizations</strong></th>
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</thead>
<tbody>
<tr>
<td>□ General guidance on feeding</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>□ Breastfeeding guidance</td>
<td></td>
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<tr>
<td>□ Formula feeding guidance</td>
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<thead>
<tr>
<th><strong>Safety</strong></th>
<th></th>
<th><strong>Follow Up/Next Visit</strong> □ 1 month of age □ 2 months of age</th>
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</thead>
<tbody>
<tr>
<td>□ Car seat safety</td>
<td></td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Heatstroke prevention</td>
<td></td>
<td></td>
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<tr>
<td>□ Safe sleep</td>
<td></td>
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<tr>
<td>□ Pets</td>
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<tr>
<td>□ Safe home environment</td>
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<tr>
<th>□ Other</th>
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**Screen Date________________________**

Name________________________________________________________________________________________  DOB____________________________

**Signature of Clinician/Title**

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WVDHHR/BPH/OMCFH/HC 01-2018
West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Sex:</th>
<th>M</th>
<th>F</th>
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<tbody>
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<thead>
<tr>
<th>Weight</th>
<th>Length</th>
<th>Weight for Length</th>
<th>HC</th>
<th>Pulse</th>
<th>BP (optional)</th>
<th>Resp</th>
<th>Temp</th>
<th>Pulse Ox (optional)</th>
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</thead>
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</tbody>
</table>

Allergies: \( \square \) NKDA

Current meds: \( \square \) None

\( \square \) Foster child | \( \square \) Child with special health care needs

Accompanied by: \( \square \) Parent | \( \square \) Grandparent | \( \square \) Foster parent | \( \square \) Foster organization

| Medical History |
|-----------------|-----------------|----------------------|
| Initial screen  | Periodic screen | Discharge weight     |
| Newborn metabolic screen | \( \square \) NL | Results in child's record |
| Newborn bilirubin screen     | \( \square \) NL | Results in child's record |
| Newborn critical congenital heart disease pulse oximetry | | Results in child's record |
| Newborn hearing screen | \( \square \) Pass | Fail | Retest | \( \square \) Results in child's record |
| Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations: | | |

\( \square \) Family health history reviewed

Concerns and/or questions

<table>
<thead>
<tr>
<th>Social/Psychosocial History</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your family's living situation?</td>
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<td>Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)?</td>
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<td>Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?</td>
</tr>
<tr>
<td>Who do you contact for help and/or support?</td>
</tr>
</tbody>
</table>

Are you and/or your partner working outside home? | \( \square \) Yes | \( \square \) No |

Child care plans?

How much stress are you and your family under now? | \( \square \) None | \( \square \) Slight | \( \square \) Moderate | \( \square \) Severe

\( \square \) Relationships (partner, family and/or friends) | \( \square \) School/work |
| \( \square \) Child care | \( \square \) Drugs | \( \square \) Alcohol | Violence/abuse (physical, emotional and/or sexual) | \( \square \) Family member incarcerated | \( \square \) Lack of support/help | \( \square \) Financial/money | \( \square \) Emotional loss | \( \square \) Health insurance | \( \square \) Other |

<table>
<thead>
<tr>
<th>Maternal Depression/Patient Health Questionnaire (PHQ-2)</th>
</tr>
</thead>
</table>

\( * \) 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

\( \square \) Not at all | \( \square \) Several days(1) | \( \square \) More than ½ the days(2)
\( \square \) Nearly every day(3)

Feeling down, depressed, or hopeless

\( \square \) Not at all | \( \square \) Several days(1) | \( \square \) More than ½ the days(2)
\( \square \) Nearly every day(3)

Concerns and/or questions

<table>
<thead>
<tr>
<th>Developmental Surveillance (( * ) Check those that apply)</th>
</tr>
</thead>
</table>

Social Language and Self-help

\( \square \) Child looks at you and follows you with his/her eyes
\( \square \) Child has self-soothing behaviors, such as bringing hands to mouth
\( \square \) Child becomes fussy when bored
\( \square \) Child calms when picked up or spoken to

Verbal Language (Expressive and Receptive)

\( \square \) Child makes brief short vowel sounds | \( \square \) Child alerts to unexpected sounds | \( \square \) Child quiets and turns to your voice | \( \square \) Child shows signs of sensitivity to environment (excessive crying, tremors, excessive startles)
\( \square \) Child has different types of cries for hunger and tiredness
\( \square \) Child has different types of cries for hunger and tiredness

Gross Motor

\( \square \) Child moves both arms and legs together
\( \square \) Child can hold chin up when on stomach

Fine Motor

\( \square \) Child can open fingers slightly when at rest

Concerns and/or questions

<table>
<thead>
<tr>
<th>Oral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water source:</td>
</tr>
</tbody>
</table>

| Nutrition/Sleep |
|-----------------|-----------------|-----------------|-----------------|
| Breastfeeding - Frequency | | | |
| Bottle feeding - Amount | | | Frequency |
| Formula | | | |
| Normal elimination | | | |
| Normal sleeping patterns | | | |
| Place on back to sleep | | | |
| Sleeps 3 to 4 hours at a time | | | |
| Can stay awake for 1 hour or longer | | | |
| Concerns and/or questions | | | |

| General Health |
|----------------|-----------------|-----------------|-----------------|
| Growth plotted on growth chart | | | |
| Do you think your child sees okay? | \( \square \) Yes | \( \square \) No |
| Do you think your child hears okay? | \( \square \) Yes | \( \square \) No |

| Nutrition/Sleep |
|-----------------|-----------------|-----------------|-----------------|
| Breastfeeding - Frequency | | | |
| Bottle feeding - Amount | | | Frequency |
| Formula | | | |
| Normal elimination | | | |
| Normal sleeping patterns | | | |
| Place on back to sleep | | | |
| Sleeps 3 to 4 hours at a time | | | |
| Can stay awake for 1 hour or longer | | | |
| Concerns and/or questions | | | |

| Nutrition/Sleep |
|-----------------|-----------------|-----------------|-----------------|
| Breastfeeding - Frequency | | | |
| Bottle feeding - Amount | | | Frequency |
| Formula | | | |
| Normal elimination | | | |
| Normal sleeping patterns | | | |
| Place on back to sleep | | | |
| Sleeps 3 to 4 hours at a time | | | |
| Can stay awake for 1 hour or longer | | | |
| Concerns and/or questions | | | |

<table>
<thead>
<tr>
<th>Risk Indicators (( * ) Check those that apply)</th>
</tr>
</thead>
</table>

Child exposed to | \( \square \) Cigarettes | \( \square \) E-Cigarettes | \( \square \) Alcohol
\( \square \) Drugs (prescription or otherwise)
Concerns and/or questions

| Continue on page 2 |

*See Periodicity Schedule for Risk Factors

*Tuberculosis Risk

\( \square \) Low risk | \( \square \) High risk

WVDHHR/BPH/OMCFH/HC 01-2018
Screen Date __________________________

Name __________________________________________________________ DOB __________________________ Age________________________ Sex: □ M  □ F

<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>Anticipatory Guidance</th>
<th>Plan of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Reflexes</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Head</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Fontanelles</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Red Reflex</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td>□ N □ Abn</td>
<td></td>
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<tr>
<td>Oral Cavity/Throat</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>□ N □ Abn</td>
<td></td>
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<tr>
<td>Heart</td>
<td>□ N □ Abn</td>
<td></td>
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<tr>
<td>Pulses</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td>□ N □ Abn</td>
<td></td>
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<tr>
<td>Back</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Hips</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td>□ N □ Abn</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signs of Abuse</th>
<th>□ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns and/or questions ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

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

Social Determinants of Health
- Living situation and food security
- Environmental tobacco exposure
- Dampness and mold
- Radon
- Pesticides
- Intimate partner violence
- Maternal alcohol and substance abuse
- Family support/help

Parental/Family Health and Well-being
- Postpartum checkup
- Maternal depression
- Family relationships

Infant Behavior and Development
- Sleeping and waking
- Fussiness and attachment
- Media (distract from child’s care)
- Playtime
- Medical home after hours support

Nutrition and Feeding
- Feeding plans and choices
- General guidance on feeding
- Breastfeeding guidance
- Formula feeding guidance

Safety
- Car seat safety
- Safe sleep
- Preventing falls (changing table, couch, bed)
- Emergency care (CPR)

Plan of Care
Assessment □ Well Child □ Other Diagnosis

Immunizations
□ UTD □ Given, see immunization record □ Entered into WVSIS

Labs
□ TB skin test (if high risk) □ Other

Referrals
□ Maternal depression - Help4WV.com/1-844-435-7496
□ Developmental
□ Other

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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit □ 2 months of age

□ Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

______________________________
Signature of Clinician/Title

WVDHHR/BPH/OMCF/HC 01-2018
## Medical History

- Initial screen
- Periodic screen

- Newborn metabolic screen
- Newborn hearing screen
- Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:

## Social/Psychosocial History

- Family health history reviewed
- Concerns and/or questions

## Developmental

**Developmental Surveillance (✓ Check those that apply)**

- Child smiles responsively
- Child makes sounds that let you know if he/she is happy
- Child makes short cool sounds
- Child lifts head and chest when on stomach
- Child keeps head steady when held in sitting position
- 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

- Breastfeeding - Frequency
- Bottle feeding - Amount
- 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**
**Anticipatory Guidance**

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

**Questions/Concerns/Notes**

**Plan of Care**

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

**Immunizations**  
- ☐ UTD  
- ☐ Given, see immunization record  
- ☐ Entered into WVSIS

**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 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**

---

**Screen Date**

**Name**

**DOB**

**Age**

**Sex:** ☐ M  ☐ F
Screen Date

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

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

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__________________________________________________________

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__________________________________________________________

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)

Concerns and/or questions__________________________________________________________

Developmental

Developmental Surveillance (☐ Check those that apply)

Social Language and Self-help ☐ Child can laugh out loud

Children can look for you or another caregiver when upset

Verbal Language (Expressive and Receptive) ☐ Child can turn to voices ☐ Child can make extended cooing sounds

Gross Motor ☐ Child can support himself/herself on elbows and wrists when on stomach ☐ Child can roll over from stomach to back

Fine Motor ☐ Child can keep his/her hands unfisted ☐ Child can play with fingers in midline ☐ Child can grasp objects

Concerns and/or questions__________________________________________________________

Oral Health

Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep

☐ Breastfeeding - Frequency ______________________________

☐ Bottle feeding - Amount_________ Frequency_________

☐ Formula

☐ Juice ☐ Water

☐ Has started solid foods ☐ Normal eating habits

Vitamins

☐ Normal elimination

☐ Normal sleeping patterns

☐ Place on back to sleep

Concerns and/or questions__________________________________________________________

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)

☐ Low risk ☐ High risk

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

Continue on page 2
### Physical Examination (N=Normal, Abn=Abnormal)

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### Anticipatory Guidance

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

#### Social Determinants of Health
- Environmental risk (lead)
- Family relationships and support
- Child care

#### Infant Behavior and Development
- Infant self-calming
- Parent-infant communication
- Consistent daily routines
- Media
- Playtime

#### Oral Health
- Maternal oral health
- Teething and drooling
- Good oral hygiene (no bottle in bed)

#### Nutrition and Feeding
- General guidance on feeding
- Feeding choices (avoid grazing)
- Delaying solid foods
- Breastfeeding guidance
- Supplements and over-the-counter medications
- Formula feeding guidance

#### Safety
- Car safety seats
- Safe sleep
- Safe home environment

#### Other

### Plan of Care

- **Assessment**
  - Well Child
  - Other Diagnosis

- **Immunizations**
  - UTD
  - Given, see immunization record
  - Entered into WVSII

- **Labs**
  - Hemoglobin/hematocrit (if high risk)
  - Other

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

- **Prior Authorizations**
  - 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

- **Follow Up/Next Visit**
  - 6 months of age
  - Other

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

### Please Print Name of Facility or Clinician

### Signature of Clinician/Title

---

**Screen Date**

**Name**

**DOB**

**Age**

**Sex:** M  F
Screen Date _______________________________________________________

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

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

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 ☐ Finanical/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)

Concerns and/or questions ________________________________________

Developmental Surveillance (✓ Check those that apply)

Social Language and Self-help ☐ Child can pat or smile at his/her reflection ☐ Child can look when you call his/her name

Verbal Language (Expressive and Receptive) ☐ Child can babble

☐ Child can make sounds like “ga”, “ma”, or “ba”

Gross Motor ☐ Child can roll over from back to stomach ☐ Child can sit briefly without support

Fine Motor ☐ Child can pass a toy from one hand to another

☐ Child can rake small objects with 4 fingers ☐ Child can bang small objects on surface

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 ☐ NA

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 ☐ Normal eating habits

☐ Vitamins

☐ Normal elimination

☐ Normal sleeping patterns

☐ Place on back to sleep

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**
- Living situation and food security
- Tobacco, alcohol, and drugs
- Parental depression
- Family relationships and support
- Child care

**Infant Behavior and Development**
- Parents as teachers
- Community and early literacy
- Media
- Emerging infant independence
- Putting self to sleep
- Self-calming

**Oral Health**
- Fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed

**Nutrition and Feeding**
- General guidance on feeding
- Solid foods
- Pesticides in vegetables and fruits
- Fluids and juice
- Breastfeeding guidance
- Formula-feeding guidance

**Safety**
- Car safety seats
- Safe sleep
- Safe home environment (burns, sun exposure, choking, poisoning, drowning, falls)

**Plan of Care**

- **Assessment**
  - Well Child
  - Other Diagnosis

- **Immunizations**
  - UTD
  - Given, see immunization record
  - Entered into WVSII

- **Labs**
  - Blood lead (if high risk) enter into WVSII
  - TB skin test (if high risk)
  - Other

- **Referrals**
  - Maternal depression - [Help4WV.com/1-844-435-7498](http://Help4WV.com/1-844-435-7498)
  - Developmental
  - Other

- **Prior Authorizations**
  - Right from the Start (RFTS) 1-800-642-9704
  - Birth to Three (BTT) 1-800-642-9704
  - Children with Special Health Care Needs (CSHCN) 1-800-642-9704
  - Women, Infants and Children (WIC) 1-304-558-0030

- **Follow Up/Next Visit**
  - 9 months of age
  - Other

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

**Please Print Name of Facility or Clinician**

**Signature of Clinician/Title**
**Medical History**

- [ ] Initial screen  
- [ ] Periodic screen

**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?
  - [ ] Accompanied by:  
  - [ ] Parent  
  - [ ] Grandparent  
  - [ ] Foster parent  
  - [ ] Foster organization  
  - [ ] 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  
  - [ ] NA

**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**

- [ ] 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**
### Anticipatory Guidance

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

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<td>☐ Other</td>
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<td>☐ Women, Infants and Children <em>(WIC)</em> 1-304-558-0030</td>
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| ☐ Screen has been reviewed and is complete               |                          |                                                  |

| Please Print Name of Facility or Clinician              |                          |                                                  |

| Signature of Clinician/Title                            |                          |                                                  |
Screen Date

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

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_________________________

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 (✓ Check those that apply)
Social Language and Self-help ☐ *Child can protoimperative point (point to request an object) ☐ *Child can imitate new gestures
☐ *Child can look for hidden objects
Verbal Language (Expressive and Receptive) ☐ *Child can babble
☐ *Child can imitate vocalizations and sounds ☐ Child can use “Dada” or “Mama” specifically ☐ Child can use 1 word other than “Mama,” “Dada,” or personal name

Gross Motor ☐ *Child can take first independent steps ☐ *Child can stand without support
Fine Motor ☐ *Child can drop an object in a cup ☐ *Child can pick up small objects with 2 finger pincer grasp ☐ *Child can pick up food and eat it

*Absence of these milestones = Autism Screen

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 ☐ NA
Concerns and/or questions_________________________

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

Dental referral required at 12 months

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

Bottled feeding - Frequency_________________________

Bottle feeding - Amount_________________________ Frequency_________________________

Formula

Plans for weaning

☐ Milk ☐ Juice ☐ Water
☐ Has started solid foods ☐ Table foods ☐ Normal eating habits
☐ Vitamins
☐ Normal elimination
☐ Normal sleeping patterns
Concerns and/or questions_________________________

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)

Hemoglobin/hematocrit required at 12 months

*Lead Risk

Blood lead required at 12 months

*Tuberculosis Risk

☐ Low risk ☐ High risk

Continue on page 2
### Physical Examination

<table>
<thead>
<tr>
<th>Area</th>
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</table>

### Anticipatory Guidance

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

#### Social Determinants of Health
- Living situation and food security
- Tobacco, alcohol, and drugs
- Social connections with family, friends, child care, home visitation program staff, and others

#### Establishing Routines
- Adjustment to child’s developmental changes and behavior
- Family time
- Bedtime, naptime, and teeth brushing
- Media

#### Feeding and Appetite Changes
- Self-feeding
- Continued breastfeeding and transition to family meals
- Nutritious foods

#### Establishing a Dental Home
- First dental checkup and dental hygiene

#### Safety
- Car safety seats
- Falls
- Drowning prevention and water safety
- Sun protection
- Pets
- Safe home environment: poisoning

### Plan of Care

<table>
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<tr>
<th>Assessment</th>
<th>Well Child</th>
<th>Other Diagnosis</th>
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<tbody>
<tr>
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<td>TB skin test</td>
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#### Feeding and Appetite Changes

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<tr>
<td>Other</td>
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#### Referrals

- Birth to Three (BT) 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 dhhr.wv.gov/healthcheck

#### Follow Up/Next Visit

- 15 months of age
- Other

#### Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title
**Screen Date**

**West Virginia Department of Health and Human Resources**

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen**

**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

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 ( □ Check those that apply)**

**Social Language and Self-help □** *Child can proclamative point (point to comment on an interesting object/event-will look alternatively between object/event and parent) □ Child can point to ask for something to get help □ Child can look around when you say things like “Where’s your ball?” or “Where’s your blanket?” □ Child can imitate scribbling □ Child can drink from a cup with little spilling**

**Verbal Language (Expressive and Receptive) □** *Child can use 3 words other than names □ Child can speak in sounds like an unknown language □ Child can follow directions that do not include a gesture**

**Gross Motor □** *Child can squat to pick up objects □ Child can crawl up a few steps □ Child can run**

**Fine Motor □** *Child can make marks with a crayon □ Child can drop an object in and take object out of a container**

*Absence of these milestones = Autism Screen* 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 □ NA Concerns and/or questions ____________________________

**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**

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 ____________________________

**Nutrition/Sleep**

□ Breastfeeding - Frequency ____________________________

□ Bottle feeding - Amount _______ Frequency _______

□ Formula ____________________________

Plans for weaning ____________________________

□ Milk □ Juice □ Water

□ Normal eating habits ____________________________

□ Vitamins ____________________________

□ Normal elimination ____________________________

□ Normal sleeping patterns ____________________________

Concerns and/or questions ____________________________

*See Periodicity Schedule for Risk Factors*

**Anemia Risk (Hemoglobin/Hematocrit)**

□ Low risk □ High risk ____________________________

*Lead Risk* □ Low risk □ High risk ____________________________

Continue on page 2
<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>Anticipatory Guidance</th>
<th>Plan of Care</th>
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<td>Assessment</td>
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<td>□ Other Diagnosis</td>
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<tr>
<td>Reflexes</td>
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<td>Immunizations</td>
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<tr>
<td>Head</td>
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<td>□ UTD</td>
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<td>□ Blood lead (if high risk) (enter into WVSIS)</td>
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<tr>
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<tr>
<td>Extremities</td>
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</tr>
</tbody>
</table>

**Signs of Abuse** □ Yes □ No

Concerns and/or questions

---

**Anticipatory Guidance**

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

**Communication and Social Development**

- Individuation
- Separation
- Finding support
- Attention to how child communicates wants and interests

**Sleep Routines and Issues**

- Regular bedtime routine, night waking, no bottle in bed

**Temperament, Development, Behavior, and Discipline**

- Conflict predictors and distraction
- Discipline and behavior management

**Healthy Teeth**

- Brushing teeth
- Reducing caries

**Safety**

- Car safety seats and parental use of seat belts
- Safe home environment: poisoning, falls, and fire safety
- Other

---

**Plan of Care**

**Assessment** □ Well Child □ Other Diagnosis

**Immunizations**

- □ UTD □ Given, see immunization record □ Entered into WVSIS

**Labs**

- □ Hemoglobin/hematocrit (if high risk)
- □ Blood lead (if high risk) (enter into WVSIS)
- □ Other

**Referrals**

- □ Developmental □ Dental
- □ Other

**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 dhhr.wv.gov/healthcheck

**Follow Up/Next Visit** □ 18 months of age

- □ Other

- □ Screen has been reviewed and is complete

---

Please Print Name of Facility or Clinician

---

Signature of Clinician/Title
**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen**

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
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<th>BP (optional)</th>
<th>Resp</th>
<th>Temp</th>
<th>Pulse Ox (optional)</th>
</tr>
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</table>

- Allergies ☐ NKDA  
- Current meds ☐ None
- Foster child ☐  
- Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization

### 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:

### Autism screening completed with an Autism Specific Tool
- M-CHAT-R/F  
- 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 ☐ NA

- Witnessed violence/abuse ☐

- Threatened with violence/abuse ☐

- Scary experience that your child cannot forget ☐

- Concerns and/or questions:

### 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

### Nutrition/Sleep
- Breastfeeding - Frequency

- Bottle feeding - Amount ☐ Frequency

- Formulas

- Plans for weaning

- Milk ☐ Juice ☐ Water

- Normal eating habits

- Vitamins

- Normal elimination

- Normal sleeping patterns

- Hours of sleep each night?

### 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

### Continue on page 2
### Physical Examination

(N=Normal, Abn=Abnormal)

<table>
<thead>
<tr>
<th>Site</th>
<th>N</th>
<th>Abn</th>
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<td>Reflexes</td>
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<td>Extremities</td>
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### Signs of Abuse

- Yes
- No

### Anticipatory Guidance

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

- **Temperament, Development, Toilet Training, Behavior and Discipline**
  - Anticipation of return to separation anxiety and managing behavior with consistent limits
  - Recognizing signs of toilet training and readiness and parental expectations
  - New sibling planned or on the way

- **Communication and Social Development**
  - Encouragement of language, use of simple words and phrases, encouragement in reading, playing, talking, and singing

- **Television Viewing and Digital Media**
  - Promotion of reading, physical activity and safe play

- **Healthy Nutrition**
  - Nutritious foods
  - Water, milk, juice
  - Expressing independence through food likes and dislikes

- **Safety**
  - Car safety seats and parental use of seat belts
  - Sun protection
  - Firearm safety
  - Safe home environment: burns, fires, and falls

- **Other**

### Plan of Care

- **Assessment**
  - Well Child
  - Other Diagnosis

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

- **Labs**
  - Hemoglobin/hematocrit (if high risk)
  - Blood lead (if high risk) (enter into WVSIS)
  - Other

- **Referrals**
  - Developmental
  - Dental
  - Other

### Prior Authorizations

- 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

### Follow Up/Next Visit

- 24 months of age
- Other

- Screen has been reviewed and is complete

### Please Print Name of Facility or Clinician

### Signature of Clinician/Title
West Virginia Department of Health and Human Resources  
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen  
24 Month Form

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<th>BP (optional)</th>
<th>Resp</th>
<th>Temp</th>
<th>Pulse Ox (optional)</th>
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</table>

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

Recent injuries, surgeries, illnesses, visits to other providers and/or counselors 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 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 (☐ Check those that apply)

☐ Child can play alongside other children, also called parallel play  
☐ Child can take off some clothing  
☐ Child can scoop well with a spoon  
☐ Child can use 50 words  
☐ Child can combine 2 words into short phrase or sentence  
☐ Child can follow 2-step command  
☐ Child can name at least 5 body parts, such as nose and hand  
☐ Child’s speech is 50% understandable to strangers  
☐ Child can kick a ball  
☐ Child can jump off the ground with 2 feet  
☐ Child can run with coordination  
☐ Child can climb up a ladder at a playground  
☐ Child can stack objects  
☐ Child can turn book pages  
☐ Child can use his/her hands to turn objects like knobs, toys, and lids  
☐ Child can draw a line  

Concerns and/or questions:

☐ Autism screening completed with an Autism Specific Tool

☐ M-CHAT-R/F  
☐ 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 ☐ NA  
☐ Witnessed violence/abuse  
☐ Threatened with violence/abuse  
☐ Scary experience that your child cannot forget  

Do you utilize a car seat for your child? ☐ Yes ☐ No  
☐ Excessive television/video game/internet/cell phone use  
Concerns and/or questions:

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
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

Nutrition/Sleep

☐ Normal eating habits  
Fruits/vegetables/lean protein per day

☐ Vitamins
☐ Normal elimination  
Toilet trained ☐ Yes ☐ No  
☐ Normal sleeping patterns  
Hours of sleep each night?  
Concerns and/or questions:

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)
☐ Low risk  
☐ High risk

*Lead Risk
Blood lead required at 24 months

*Tuberculosis Risk
☐ Low risk  
☐ High risk

*Dyslipidemia Risk
☐ Low risk  
☐ High risk

Continue on page 2
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 ____________

Signs of Abuse  □ Yes  □ No
Concerns and/or questions__________________________

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

Social Determinants of Health
- Intimate partner violence
- Living situation and food security
- Tobacco, alcohol, and drugs
- Parental well-being

Temperament and Behavior
- Development
- Temperament
- Promotion of physical activity and safe play
- Limits on media use

Assessment of Language Development
- How child communicates and expectations for language
- Promotion of reading

Toilet Training
- Techniques
- Personal hygiene

Safety
- Car safety seats
- Outdoor safety
- Firearm safety
- Other__________________________

Plan of Care
Assessment □ Well Child □ Other Diagnosis

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

Labs
- Hemoglobin/hematocrit (if high risk)
- Blood lead (required at 24 months) (enter into WVSIS)
- TB skin test (if high risk)
- Lipid profile (if high risk)
- Other ______________________

Referrals
- Developmental  □ Dental  □ Blood lead ≥5ug/dl
- Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
- Other ______________________

- 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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit □ 30 months of age
- Other____________________

□ Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date __________________________
DOB __________________________
Age __________________________
Sex: □ M  □ F
**Screen Date**

**West Virginia Department of Health and Human Resources**

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen**

**Name**

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
<th>Pulse</th>
<th>BP</th>
<th>Resp</th>
<th>Temp</th>
<th>Pulse Ox (optional)</th>
</tr>
</thead>
</table>

**DOB**

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex: □ M □ F</th>
</tr>
</thead>
</table>

**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

**Recent injuries, surgeries, illnesses, visits to other providers and/or counselors 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 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?**

---

**Nutrition/Sleep**

□ Normal eating habits

**Fruits/vegetables/lean protein per day**

□ Vitamins

□ Normal elimination

**Toilet trained** □ Yes □ No

□ Normal sleeping patterns

**Hours of sleep each night?**

---

**General Health**

□ Growth plotted on growth chart

**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 □ NA

□ Witnessed violence/abuse

□ Threatened with violence/abuse

□ Scary experience that your child cannot forget

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

□ Excessive television/video game/internet/cell phone use

**Concerns and/or questions**

---

**Developmental**

□ Developmental surveillance and screening completed with

**Standardized Screening Tool**

□ ASQ3 □ Other tool

**Results in child’s record** □ Yes □ No

**Concerns and/or questions**

---

**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

**Nutrition/Sleep**

□ Normal eating habits

**Fruits/vegetables/lean protein per day**

□ Vitamins

□ Normal elimination

**Toilet trained** □ Yes □ No

□ Normal sleeping patterns

**Hours of sleep each night?**

---

*See Periodicity Schedule for Risk Factors*

*Anemia Risk (Hemoglobin/Hematocrit)*

□ Low risk □ High risk

*Lead Risk*

□ Low risk □ High risk

*Tuberculosis Risk*

□ Low risk □ High risk

---

Continue on page 2
**Physical Examination (N=Normal, Abn=Abnormal)**

<table>
<thead>
<tr>
<th>General Appearance</th>
<th>☐ N ☐ Abn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Neurological</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Reflexes</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Head</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Neck</td>
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</tr>
<tr>
<td>Eyes</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Red Reflex</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Ocular Alignment</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Ears</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Nose</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Oral Cavity/Throat</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Lung</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Heart</td>
<td>☐ N ☐ Abn</td>
</tr>
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<td>Pulses</td>
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<td>Genitalia</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Back</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Hips</td>
<td>☐ N ☐ Abn</td>
</tr>
<tr>
<td>Extremities</td>
<td>☐ N ☐ Abn</td>
</tr>
</tbody>
</table>

**Signs of Abuse**

☐ Yes ☐ No

Concerns and/or questions________________________________

---

**Anticipatory Guidance**

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

**Social Determinants of Health**

☐ Intimate partner violence
☐ Living situation and food security
☐ Tobacco, alcohol, and drugs
☐ Parental well-being

**Temperament and Behavior**

☐ Development
☐ Temperament
☐ Promotion of physical activity and safe play
☐ Limits on media use

**Assessment of Language Development**

☐ How child communicates and expectations for language
☐ Promotion of reading

**Toilet Training**

☐ Techniques
☐ Personal hygiene

**Safety**

☐ Car safety seats
☐ Outdoor safety
☐ Firearm safety

☐ Other ________________________________________________

---

**Plan of Care**

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIS

Labs

☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk)* *(enter into WVSIS)*
☐ TB skin test *(if high risk)*
☐ Other ________________________________________________

Referrals

☐ Developmental ☐ Dental
☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
☐ Other ________________________________________________

☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704
☐ Women, Infants and Children (WIC) 1-304-558-0030
☐ Birth to Three (BTT) transition planning

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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 3 years of age

☐ Other_________________________________________________

☐ Screen has been reviewed and is complete

---

Please Print Name of Facility or Clinician

_____________________________________________________

Signature of Clinician/Title

_____________________________________________________

---

**WVDHHR/BPH/OMCF/HC 01-2018**
Screen Date

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Health Check Program Preventive Health Screen

West Virginia Department of Health and Human Resources

3 Year Form

Name ____________________________________________ DOB ____________________________ Age ____________________ Sex: □ M □ F

Weight __________ Height __________ BMI __________ Pulse __________ BP __________ Resp __________ Temp __________ Pulse Ox (optional) __________

Allergies □ NKDA ____________________________

Current meds □ None ____________________________

□ Foster Child ____________________________ □ 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 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 □ 

Child can understand □ 

Child can draw a person □ 

Child can tell you a story from a book or TV □ 

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 behavior, speech, learning, social or motor skills ____________________________

Immunizations: Attach current immunization record

□ UTD □ Given, see immunization record □ Entered into WVSIS ____________________________

Referrals: □ Developmental ____________________________

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

□ Dental □ Vision □ Hearing ____________________________

□ Other ____________________________

□ Children with Special HealthCare Needs (CSHCN) 1-800-662-9704 ____________________________

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

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 ____________________________

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

□ Family health history reviewed ____________________________

Concerns and/or questions ____________________________

Social/Psychosocial History

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 ____________________________

Developmental

Child care/after school care ____________________________

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 ____________________________

Is your child in school? □ Yes □ No ____________________________

Favorite thing about school ____________________________

Any problems? ____________________________

Activities outside school ____________________________

Peer relationships/friends □ Good □ Okay □ Poor ____________________________

Risk Indicators (✓ Check those that apply) ____________________________

Child exposed to □ Cigarettes □ E-Cigarettes □ 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 ____________________________

General Health

□ Growth plotted on growth chart ____________________________

□ BMI calculated and plotted on BMI chart ____________________________

Continue on page 2
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?

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)
□ Low risk □ High risk

*Tuberculosis Risk
□ Low risk □ High risk

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 □ Yes □ No
Concerns and/or questions

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

Social Determinants of Health
□ Living situation and food security
□ Tobacco, alcohol, and drugs
□ Positive family interactions
□ Work-life balance

Playing with Siblings and Peers
□ Play opportunities and interactive games
□ Sibling relationships

Encouraging Literacy Activities
□ Reading, talking, and singing together
□ Language development

Promoting Healthy Nutrition and Physical Activity
□ Water, milk, and juice
□ Nutritious foods
□ Competence in motor skills and limits on inactivity

Safety
□ Car safety seats
□ Choking prevention
□ Pedestrian safety and falls from windows
□ Water safety
□ Pets
□ Firearm safety

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 WVSIS)
□ TB skin test (if high risk)
□ Other

Referrals
See page 1, school requirements

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 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
Screen Date

Name

DOB

Age

Sex: □ M □ F

Weight

Height

BMI

Pulse

BP

Resp

Temp

Pulse Ox (optional)

Allergies □ NKDA

Current meds □ None

☐ Foster Child  □ 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:

□ UTO (retest in 6 months)

Wears glasses?  □ Yes  □ No

Hearing Screen

20 db@

R ear ______ 500HZ  R ear ______ 1000HZ ______ 2000HZ ______ 4000HZ

L ear ______ 500HZ  L ear ______ 1000HZ ______ 2000HZ ______ 4000HZ

Wears hearing aids?  □ Yes  □ No

Developmental Surveillance (✓ Check those that apply)

☐ Child can enter bathroom and have a bowel movement by himself/herself

☐ Child can brush his/her teeth

☐ Child can dress and undress without much help

☐ Child can engage in well-developed imaginative play

☐ Child can answer simple questions

☐ Child can speak in words that are 100% understandable to strangers

☐ Child can draw pictures that you recognize

☐ Child can follow simple rules when playing games

☐ Child can tell you a story from a book

☐ Child can skip on 1 foot

☐ Child can climb stairs, alternating feet, without support

☐ Child can draw a simple cross

☐ Child can unbutton and button medium sized buttons

☐ Child can grasp pencil with thumb and fingers instead of fist

☐ Concerns about child’s behavior, speech, learning, social or motor skills

Declarative

Immunizations: Attach current immunization record

☐ UTD  ☐ Given, see immunization record  ☐ Entered into WVSIS

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

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

☐ Family health history reviewed

Concerns and/or questions:

Social/Psychosocial History

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

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

Is your child in school?  □ Yes  □ No

Favorite thing about school

Any problems?

Activities outside school

Peer relationships/friends  □ Good  □ Okay  □ Poor

Risk Indicators (✓ Check those that apply)

Child exposed to  □ Cigarettes  □ E-Cigarettes  □ 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

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Continue on page 2
Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day ________________
Vitamins ☐ Normal ☐ Abnormal
□ Normal elimination
□ Physical activity/exercise an hour most days
□ Type of physical activity/exercise
Normal sleeping patterns? ☐ Yes ☐ No
□ Hours of sleep each night ________________
□ Lead Risk ☐ Low ☐ High
□ Anemia Risk (Hemoglobin/Hematocrit) ☐ Low ☐ High
□ Tuberculosis Risk ☐ Low ☐ High
□ Dyslipidemia Risk ☐ Low ☐ High

Physical Examination (N=Normal, Abn=Abnormal)
General Appearance  ☐ N  ☐ Abn
Skin  ☐ N  ☐ Abn
Neurological  ☐ N  ☐ Abn
Reflexes  ☐ N  ☐ Abn
Head  ☐ N  ☐ Abn
Nose  ☐ 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 ☐ Yes ☐ No

Concerns and/or questions________________________________________________________

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

Social Determinants of Health
☐ Living situation and food security
☐ Tobacco, alcohol, and drugs
☐ Intimate partner violence
☐ Safety in the community
☐ Engagement in the community

School Readiness
☐ Language understanding and fluency
☐ Feelings
☐ Opportunities to socialize with other children
☐ Readiness for structured learning experiences
☐ Early childhood programs and preschool

Developing Healthy Nutrition and Personal Habits
☐ Milk, water, and juice
☐ Nutritious foods
☐ Daily routines that promote health

Media Use
☐ Limits on use
☐ Promoting physical activity and safe play

Safety
☐ Belt-positioning car booster seats
☐ Outdoor safety
☐ Water safety
☐ Sun protection
☐ Pets
☐ Firearm safety
☐ Other __________________________________________________________

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 WVSIS)
☐ TB skin test (if high risk)
☐ Lipid profile (if high risk)
☐ Other ____________________________

Referrals
See page 1, school requirements

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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 5 years of age
☐ Other ____________________________

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature
Screen Date__________________________

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

Name__________________________ DOB__________________________ Age__________________________ Sex: □ M □ F

Weight__________________________ Height__________________________ BMI__________________________

Pulse__________________________ BP__________________________ Resp__________________________ Temp__________________________

Allergies □ NKDA ____________________________________________________________________________

Current meds □ None ____________________________________________________________________________

□ Foster Child ____________________________ □ Child with special health care needs ____________________________ □ IEP/section 504 in place ____________________________

Accompanied by □ Parent □ Grandparent □ Foster parent □ Foster organization ____________________________________________________________________________

Oral Health
Date of last dental visit ____________________________

Current oral health problems ____________________________________________________________________________

Water source □ Public □ Well □ Tested ____________________________

Fluoride supplementation □ Yes □ No ____________________________

Fluoride varnish applied (5 years, apply every 3 to 6 months) □ Yes □ No ____________________________

Vision Acuity Screen:
R ____________________________ L ____________________________
Weary glasses? □ Yes □ No ____________________________

Hearing Screen
20 db@  500HZ  1000HZ  2000HZ  4000HZ ____________________________

L ____________________________ 500HZ  1000HZ  2000HZ  4000HZ ____________________________

Wears hearing aids? □ Yes □ No ____________________________

Developmental
Developmental Surveillance (✓ Check those that apply)

Child can balances on one foot, hops and skips ____________________________

Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles ____________________________

Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors ____________________________

Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance ____________________________

Concerns about child’s behavior, speech, learning, social or motor skills ____________________________

Immunizations: Attach current immunization record

□ UTD □ Given, see immunization record □ Entered into WVSIIIS ____________________________

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 ____________________________

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 ____________________________

School Entry Requirements ____________________________

Medical History

□ Initial Screen □ Periodic Screen ____________________________

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

□ Family health history reviewed ____________________________

Concerns and/or questions ____________________________

Social/Psychosocial History

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 ____________________________

Risk Indicators (✓ Check those that apply)

Child exposed to □ Cigarettes □ E-Cigarettes □ 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 ____________________________

Does your child wear protective gear, including seat belts? □ Yes □ No ____________________________

□ Excessive television/video game/internet/cell phone use ____________________________

General Health

□ Growth plotted on growth chart ____________________________

□ BMI calculated and plotted on BMI chart ____________________________

Continue on page 2 ____________________________
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?______________________________

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)
□ Low risk  □ High risk

*Lead Risk
□ Low risk  □ High risk

*Tuberculosis Risk
□ Low risk  □ High risk

*Dyslipidemia Risk (year 6)
□ Low risk  □ High risk

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___________________________
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  □ Yes  □ No
Concerns and/or questions___________________________________________________________

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

Social Determinants of Health
□ Neighborhood and family violence
□ Food security
□ Family substance use (tobacco, alcohol, drugs)
□ Emotional security and self-esteem
□ Connectedness with family

Developmental and Mental Health
□ Family rules and routines
□ Concern and respect for others
□ Patience and control over anger

School
□ Readiness
□ Established routines and school attendance
□ Friends
□ After school care
□ Parent - teacher communication

Physical Growth and Development
□ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
□ Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, healthy foods in school)
□ Physical activity (60 minutes per day)

Safety
□ Car safety
□ Outdoor safety
□ Water safety
□ Sun protection
□ Harm from adults (sexual abuse)
□ Home fire safety
□ Firearm safety

Other
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

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 WVSIIS)
□ TB skin test (if high risk)
□ Lipid profile (year 6, if high risk)
□ Other______________________________

Referrals
See page 1, school requirements

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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit  □ 6 years of age  □ 7 years of age
□ Other______________________________

□ Screen has been reviewed and is complete
See page 1, school requirements for required signature
West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name______________________________DOB________________________Age________________Sex: □ M □ F
Weight________________Height________________BMI__________Pulse________BP________Resp________Temp________Pulse Ox (optional)

Allergies □ NKDA
Current meds □ None
□ Foster Child □ 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 WVSIS

Oral Health
Date of last dental visit________________________Current oral health problems________________________
Water source □ Public □ Well □ Tested
Fluoride supplementation □ Yes □ No

Vision Acuity Screen:
R __________________ L __________________
Wears glasses? □ Yes □ No

Hearing Screen
20 db@
R ear ______ 500HZ R ear ______ 1000HZ ______ 2000HZ ______ 4000HZ
L ear ______ 500HZ L ear ______ 1000HZ ______ 2000HZ ______ 4000HZ
Wears hearing aids? □ Yes □ No

□ Developmental Surveillance
Concerns about behavior, speech, learning, social or motor skills________________________

Referrals:
□ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
□ Dental □ Vision □ Hearing
□ Other __________________________
□ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

Please Print Name of Facility or Clinician

Signature of Clinician/Title

Medical History
□ Initial Screen □ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:

□ Family health history reviewed
Concerns and/or questions:

Social/Psychosocial History
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 __________________________

How much stress are you and your family under now?
□ None □ Slight □ Moderate □ Severe
What kind of stress? (✓ Check those that apply)
□ Relationships (parent, 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 __________________________

Grade in school________________________
Favorite subject________________________
Any problems?
Activities outside school __________________________
Peer relationships/friends □ Good □ Okay □ Poor

Risk Indicators (✓ Check those that apply)
Exposure to □ Cigarettes □ E-Cigarettes □ 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

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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? __________________________

Continue on page 2
Screen Date ______________________

Name ____________________________________________________________ DOB ______________________ Age ___________ Sex: □ M □ F

---

**Possible Signs of Abuse**

- Yes □ Yes □ No

Concerns and/or questions ____________________________________________

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**Anticipatory Guidance**

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

- Social Determinants of Health
  - Neighborhood and family violence (bullying, fighting)
  - Food security
  - Family substance use (tobacco, e-cigarettes, alcohol, drugs)
  - Harm from the internet
  - Emotional security and self-esteem
  - Connectedness with family and peers

- Developmental and Mental Health
  - Independence, rules and consequences, temper problems and conflict resolution
  - Puberty and pubertal development

- School
  - Adaption to school, school problems (behavior or learning issues), school performance and progress, school attendance, individual education program or special education services, involvement in school activities and after-school programs

- Physical Growth and Development
  - Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
  - Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, limiting added sugars intake)
  - Physical activity (60 minutes per day, screen time)

- Safety
  - Car safety
  - Safety during physical activity
  - Water safety
  - Sun protection
  - Harm from adults (physical/sexual abuse)
  - Firearm safety

- Other ____________________________________________________________

---

**Plan of Care**

Assessment □ Well Child □ Other Diagnosis

- Labs
  - Hemoglobin/hematocrit (if high risk)
  - TB skin test (if high risk)
  - Lipid profile (if high risk)
  - Other ____________________________________________________________________________

- Referrals
  - See page 1, school requirements

- 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 dhhr.wv.gov/healthcheck

- Follow Up/Next Visit □ 8 years of age □ 9 years of age

- Other ____________________________________________________________________________

- □ Screen has been reviewed and is complete

- See page 1, school requirements for required signature
West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

### Name
DOB: ____________________
Age: ____________________
Sex: [ ] M [ ] F

### Weight
Height: ____________________
BMI: ____________________
Pulse: ____________________
BP: ____________________
Resp: ____________________
Temp: ____________________
Pulse Ox (optional): ____________________

### Allergies
[ ] NKDA

### Current meds
[ ] None

### Foster Child
[ ] Foster Child
[ ] Child with special health care needs
[ ] IEP/section 504 in place

### Accompanied by
[ ] Parent
[ ] Grandparent
[ ] Foster parent
[ ] Foster organization
[ ] Other

### Medical History
- Initial Screen
- Periodic screen
- Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:

### Social/Psychosocial History
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

### Concerns about behavior, speech, learning, social or motor skills

### Concerns about moodiness or depression

### 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

### 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
[ ] A little bit
[ ] Moderately
[ ] Quite a bit
[ ] Extremely

### Feeling very upset when something reminded you of a stressful experience from the past?
[ ] Not at all
[ ] A little bit
[ ] Moderately
[ ] Quite a bit
[ ] Extremely

### Traumatic Stress Reactions/PCL-C
*Positive screen = numbered responses 4 or greater

### Risk Indicators (Check those that apply)
- Exposure to
  - Cigarettes
  - E-Cigarettes
  - 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
- Thoughts/plans to harm
- Self
- Others
- Animals
- NA
- Do you wear protective gear, including seat belts?
- Yes [ ] No
- Excessive television/video game/internet/cell phone use

### 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:

### Oral Health
- Date of last dental visit
- Current oral health problems
- Water source
- [ ] Public
- [ ] Well
- [ ] Tested
- Fluoride supplementation
- [ ] Yes [ ] No

### Vision Acuity Screen: (Objective 10 years)
- R __________ L __________
- Wears glasses?
- [ ] Yes [ ] No

### Hearing Screen (Objective 10 years)
- 20db@
- R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
- L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
- Wears hearing aids?
- [ ] Yes [ ] No

### Wears hearing aids?
- [ ] Yes [ ] No

*See Periodicity Schedule for Risk Factors

### Anemia Risk (Hemoglobin/Hematocrit)
- Low risk
- High risk

### Tuberculosis Risk
- Low risk
- High risk

### Dyslipidemia Risk
- Low risk
- High risk
- Fasting lipoprotein required once between 9 and 11 years

### Continue on page 2

**Physical Examination**  
(N=Normal, Abn=Abnormal)

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Abn</th>
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<td>Reflexes</td>
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<td>Heart</td>
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<td>Pulses</td>
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<td>Abdomen</td>
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If female:

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<td>Hips</td>
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<tr>
<td>Extremities</td>
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</tr>
</tbody>
</table>

**Possible Signs of Abuse**  
Yes  No

Concerns and/or questions

---

**Anticipatory Guidance**

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

**Social Determinants of Health**

- Neighborhood and family violence (fighting, bullying)
- Food security
- Family substance use (tobacco, e-cigarettes, alcohol, drugs)
- Harm from the internet
- Emotional security and self esteem
- Connectedness with family and peers

**Development and Mental Health**

- Temper problems, setting reasonable limits, friends
- Sexuality (pubertal onset, personal hygiene, initiation of growth spur, menstruation and ejaculation, loss of baby fat and accretion of muscles, sexual safety)

**School**

- School attendance, school problems (behavior or learning), school performance and progress, transitions, co-occurrence of middle school and pubertal transactions

**Physical and Growth Development**

- Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
- Nutrition (healthy weight, disordered eating behaviors, importance of breakfast, limits on saturated fat and added sugars, healthy snacks)
- Physical activity (60 minutes per day, after school activities)

**Safety**

- Car safety
- Safety during physical activity
- Water safety
- Sun protection
- Knowing child’s friends and their families
- Firearm safety

**Plan of Care**

**Assessment**

- Well Child  Other Diagnosis

**Immunizations**

- UTD  Given, see immunization record  Entered into WVSIS

**Labs**

- Hemoglobin/hematocrit (if high risk)
- TB skin test (if high risk)
- Fasting lipoprotein (once between 9 and 11 years and/or high risk)

**Referrals**

- Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
- Dental  Vision  Hearing  Other

**Children with Special HealthCare Needs (CSHCN)**

1-800-642-9704

**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 dhhr.wv.gov/healthcheck

**Follow Up/Next Visit**

- 10 years of age  11 years of age
- Other

**Screen has been reviewed and is complete**

**Please Print Name of Facility or Clinician**

---

**Signature of Clinician/Title**
## West Virginia Department of Health and Human Resources

### Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

#### Name __________________________ DOB __________________________ Age __________________________ Sex: □ M □ F

<table>
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<tr>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
<th>Pulse</th>
<th>BP</th>
<th>Resp</th>
<th>Temp</th>
<th>Pulse Ox (optional)</th>
</tr>
</thead>
</table>

**Allergies** □ NKDA ____________________________________________________________

**Current meds** □ None _________________________________________________________

- Foster Child □ Child with special health care needs □ IEP/section 504 in place

**Accompanied by** □ Parent □ Grandparent □ Foster parent □ Foster organization ____________________________________________________________

### Immunizations:

- **Attach current immunization record**
  - □ UTD □ Given, see immunization record □ Entered into WVSIS

### Oral Health

- **Date of last dental visit** __________________________
  - □ 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

- **6000HZ** _______ 8000HZ
  - Wears hearing aids? □ Yes □ No

### Developmental Surveillance

- Concerns about behavior, speech, learning, social and/or motor skills

### Medical History

- **Initial Screen** □ Periodic screen
  - Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:

- □ Family health history reviewed

### Social/Psychosocial History

- 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

### School Entry Requirements

- **Please Print Name of Facility or Clinician**

- **Signature of Clinician/Title**

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### 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 (FP) 1-800-642-9704
- □ Children with Special Health Care Needs (CSHCN) 1-800-642-9704

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### 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 □ 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)

### Risk Indicators (√ Check those that apply)

- □ None identified □ Tobacco use □ Cigarettes # per day

### 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 □ A little bit(1) □ Moderately(2) □ Quite a bit(3) □ Extremely(4)

### Continuing on page 2
Screen Date _______________________

Name ___________________________ DOB __________________________ Age ___________ Sex: ☐ M ☐ F

□ 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

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, exercise an hour most days
Type of physical activity/exercise
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night? __________________________

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)
☐ Low risk ☐ High risk

*Tuberculosis Risk
☐ Low risk ☐ High risk

*Dyslipidemia Risk
☐ Low risk ☐ High risk

Fasting lipoprotein required once between 9 and 11 years

*STI Risk
☐ Low risk ☐ High risk

*HIV Risk
☐ Low risk ☐ High risk

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 __________________________

□ Abnormal

If female:
LMP __________________________
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe
Genitalia ☐ N ☐ Abn __________________________
Back ☐ N ☐ Abn __________________________
Hips ☐ N ☐ Abn __________________________
Extremities ☐ N ☐ Abn __________________________

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions __________________________

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

Social Determinants of Health
☐ Interpersonal violence (fighting, bullying)
☐ Living situation and food security
☐ Family substance use (tobacco, e-cigarettes, alcohol, drugs)
☐ Connectedness with family and peers
☐ Connectedness with community
☐ School performance
☐ Coping with stress and decision making

Physical Health and Health Promotion
☐ Oral health
☐ Body image
☐ Healthy eating
☐ Physical activity and sleep

Emotional Well-being
☐ Mood regulation and mental health
☐ Sexuality

Risk Reduction
☐ Pregnancy and sexually transmitted infections
☐ Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
☐ Acoustic trauma

Safety
☐ Seat belt and helmet use
☐ Substance use and riding in a vehicle
☐ Firearm safety
☐ Other

Plan of Care
Assessment ☐ Well Child ☐ 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)
☐ Other

Referrals
See page 1, school requirements

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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 12 years of age ☐ 13 years of age
☐ 14 years of age
☐ Other __________________________

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature
Screen Date ____________________________________________

West Virginia Department of Health and Human Resources
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

Weight________ Height________ BMI________ Pulse________ BP________ Resp________ Temp________ Pulse Ox (optional)________

Allergies □ NKDA

Current meds □ None

☐ Foster Child ___________________________________________ ☐ Child with special health care needs_______________________ ☐ IEP/section 504 in place_____________________

Accompanied by □ N/A □ Parent □ Grandparent □ Foster parent □ Foster organization__________________________ ☐ Other________

Immunizations: Attach current immunization record
☐ UTD □ Given, see immunization record □ Entered into WVSIS

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 behavior, speech, learning, social and/or motor skills__________________________

Medical History
☐ Initial Screen □ Periodic screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:

☐ Family health history reviewed__________________________
Concerns and/or questions__________________________

Social/Psychosocial History
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?__________________________

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__________________________

Concerns and/or questions__________________________

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 □ 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 □ 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 □ 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)

Risk Indicators (✓ Check those that apply)
□ None identified □ *Tobacco use □ Cigarettes # per day__________
□ E-Cigarettes □ *Cheew □ 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
Thoughts/plans to harm □ Self □ Others □ Animals □ NA

Continue on page 2
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

---

**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_____________________
- Normal sleeping patterns? [ ] Yes [ ] No  
- Hours of sleep each night?______________________________

**Possible Signs of Abuse**

- Concerns and/or questions______________________________

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**Anticipatory Guidance**

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

**Social Determinants of Health**

- Interpersonal violence (fighting, bullying)  
- Living situation and food security  
- Family substance use (tobacco, e-cigarettes, alcohol, drugs)  
- Connectedness with family and peers  
- Connectedness with community  
- School/work performance  
- Coping with stress and decision making

**Physical Health and Health Promotion**

- Oral health  
- Body image  
- Healthy eating  
- Physical activity and sleep

**Emotional Well-being**

- Mood regulation and mental health  
- Sexuality

**Risk Reduction**

- Pregnancy and sexually transmitted infections  
- Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs  
- Acoustic trauma

---

**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 18 years, if sexually active and/or high risk)  
- Other

**Referrals**

See page 1, school requirements

**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 dhhr.wv.gov/healthcheck

**Follow Up/Next Visit**  □ 16 years of age □ 17 years of age  
□ Other________________________

□ Screen has been reviewed and is complete

See page 1, school requirements for required signature
Screen Date _______________________________________________________

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

Name ____________________________ DOB ____________ Age ____________ Sex: □ M □ F

Weight __________________________ Height ____________ BMI ________ Pulse _______ BP _______ Resp _______ Temp _______ Pulse Ox (optional) _______

Allergies □ NKDA __________

Current meds □ None ________

□ Child with special health care needs ________ □ IEP/section 504 in place ________

Accompanied by □ N/A □ Parent □ Grandparent □ Other ________

Medical History
□ Initial Screen □ Periodic screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: ____________________________

□ Family health history reviewed ________

Concerns and/or questions ____________________________________________

Social/Psychosocial History
What is your living situation? ____________________________

Are you in school? □ No □ High school □ College/vocational
Working? □ Yes □ No ________

What are your future plans? ____________________________

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

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ 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 (parent, family and/or friends) □ School/work

□ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/or sexual) □ Family member incarcerated □ Lack of support/help

□ Financial/money □ Emotional loss □ Health insurance

Other ____________________________

Concerns and/or questions ____________________________________________

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 □ 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 □ 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 □ 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)

Risk Indicators (✓ Check those that apply)
□ None identified □ Tobacco use □ Cigarettes # per day

□ E-Cigarettes □ 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
Thoughts/plans to harm Self □ Others □ Animals □ NA

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 ________

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? ________

Oral Health
Date of last dental visit ________

Current oral health problems ________

Vision Acuity Screen: (Subjective 18-20 years)

R ____________ L ____________

Wears glasses? □ Yes □ No ________

Hearing Screen (Objective once between 18 and 20 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 ________

Continue on page 2

**Screen Date________________________**

Name________________________________________________________________________________________  DOB____________________________

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)
- Low risk
- High risk

*Tuberculosis Risk
- Low risk
- High risk

*Dyslipidemia Risk
- Low risk
- High risk

Fasting lipoprotein required once between 17 and 20 years

*STI Risk
- Low risk
- High risk

*HIV Risk
- Low risk
- High risk

HIV test required once between 15 and 18 years

**Physical Examination (N=Normal, Abn=Abnormal)**

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<th>General Appearance</th>
<th>N</th>
<th>Abn</th>
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<tbody>
<tr>
<td>Skin</td>
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<tr>
<td>Neurological</td>
<td>N</td>
<td>Abn</td>
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<tr>
<td>Reflexes</td>
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<td>Abn</td>
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<td>Abn</td>
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<tr>
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<td>Abn</td>
</tr>
<tr>
<td>Heart</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Pulses</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Abdomen</td>
<td>N</td>
<td>Abn</td>
</tr>
</tbody>
</table>

If female:

LMP

Bleeding
- Normal
- Heavy

Craming
- No
- Slight
- Severe

Genitalia
- N
- Abn

Back
- N
- Abn

Hips
- N
- Abn

Extremities
- N
- Abn

**Possible Signs of Abuse**
- Yes
- No

Concerns and/or questions______________________________

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**Anticipatory Guidance**

(Consult Bright Futures, Fourth Edition for further information)

https://brightfutures.aap.org

**Social Determinants of Health**

- Interpersonal violence
- Living situation and food security
- Family substance use (tobacco, e-cigarettes, alcohol, drugs)
- Connectedness with family and peers
- Connectedness with community
- School/work performance
- Coping with stress and decision making

**Physical Health and Health Promotion**

- Oral health
- Body image
- Healthy eating
- Physical activity and sleep
- Transition to adult care

**Emotional Well-being**

- Mood regulation and mental health
- Sexuality

**Risk Reduction**

- Pregnancy and sexually transmitted infections
- Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
- Acoustic trauma

**Safety**

- Seat belt and helmet use
- Driving and substance use
- Sun protection
- Firearm safety

**Other**

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**Plan of Care**

Assessment
- Well Child
- Other Diagnosis

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

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 18 years, if sexually active and/or high risk)

**Physical Determinants of Health**

- Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
- Substance abuse - Help4WV.com/1-844-435-7498
- Dental - Vision - Hearing
- Other

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**Referrals**

- Family Planning (FP) 1-800-642-9704
- Children with Special HealthCare Needs (C SHCN) 1-800-642-9704
- Transition to adult-oriented health care/medical home

**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 dhhr.wv.gov/healthcheck

Follow Up/Next Visit
- 19 years of age
- 20 years of age
- Other

**Screen has been reviewed and is complete**

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Please Print Name of Facility or Clinician

Signature of Clinician/Title