Screen Date_____

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

**12 Month Form**

Name_____ DOB_____ Age_____ Sex: M F Wt_____ Ht_____ HC_____ Pulse_____ Temp_____

Allergies: □ NKDA _____ Current Meds: □ None_____

Accompanied by: □ Parent □ Grandparent □ Foster parent □ Foster organization □ Other _____

**History:** □ No change
Concerns and questions:

Follow up on previous concerns:

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

## Social Emotional Health/Interpersonal Trauma[1]

**Social/Family:** ✓ ***Check those that apply***
□ Family situation change □ No change

_____
Has your child lived anywhere but with parent(s)/caretaker(s)?
□ Yes □ No _____
Parent(s)/Caretaker(s) working outside home? □ Yes □ No
Child care? □ Yes □ No _____
Ability to separate from parent(s)/caretaker(s)? □ Yes □ No
Sibling(s) in the home? □ Yes □ No _____

**Social Emotional/Stress Indicators:** ✓ ***Check those that apply***
Is there stress in the home? □ Yes □ No
_____
Who do you call for help? _____
_____

**Risk Indicators:** ✓ ***Check those that apply***
**Exposure to:** □ Passive Smoke □ Cigarettes □ E-Cigs
□ Chew □ Alcohol □ Other drugs_____
Are there weapon(s) in the home? □ Yes □ No
Are the weapon(s) secured? □ Yes □ No □ NA
Do you utilize a car seat for your child? □ Yes □ No

## Developmental

**Developmental Surveillance:** ✓ ***Check those that apply***
**Gross Motor:** □ Pulls self to standing □ Crawls
□ Walks with support
**Fine Motor:** □ Feeds self with fingers, drinks from cup
□ Pincer grasp □ Bangs two blocks together
**Communication:** □ Uses 1- 2 words
□ Imitates vocalizations and sounds* □ Babbling*
**Social:** □ Protodeclarative pointing*
□ Social smile □ Waves bye-bye
□ Peekaboo □ Looks at pictures
□ Patty-cake □ Looks for dropped or hidden objects

□ ***Absence of these milestones=Autism Screen***

## Physical Health

**Current Health Indicators:** ✓ ***Check those that apply***
□ No change
Changes since last visit:

Do you think your child sees okay? □ Yes □ No

Do you think your child hears okay? □ Yes □ No

**Oral Health Screen:** ✓ ***Check those that apply***
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Tooth eruption
□ Current oral health problems _____

**Dental referral required at 12 months**

**Nutrition:** ✓ ***Check those that apply***
□ Breast feeding; Frequency _____
□ Bottle feeding; Amount_____ Frequency_____
□ Formula _____
□ Milk □ Juice □ Water
□ Has started solid foods □ Normal eating habits
□ Vitamins_____

□ Normal elimination_____

□ Normal sleep patterns _____

***See Periodicity Schedule for risk indicators***
**Tuberculosis Risk:** □ Low risk □ High risk

**Lead Risk: Blood lead required at 12 months**

**Hemoglobin/Hematocrit Risk: HGB/HCT required at 12 months**

**Physical Examination:** ✓ ***= Normal limits***

| | | |
|---|---|---|
| □ General Appearance | | □ Skin |
| □ Neurological | | □ Reflexes |
| □ Head | □ Fontanelles | □ Neck |
| □ Eyes | □ Red Reflex | □ Ocular Alignment |
| □ Ears | □ Nose | |
| □ Oral Cavity/Throat | | □ Lung |
| □ Heart | □ Pulses | □ Abdomen |
| □ Genitalia | □ Back | □ Hips |
| □ Extremities | | |

**Possible Signs of Abuse** □ Yes □ No

**Health Education:**
□ Discussed □ Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

□ **Risk indicators reviewed/screen complete**

**Assessment:** □ **Well Child** □ **Other Diagnosis**

**Immunizations: Attach current immunization record**
□ **UTD** □ Given, see vaccine record

**Labs:** □ HGB/HCT required at 12 months
□ Blood lead required at 12 months

**Referrals:** □ Developmental □ **Dentist** □ Blood lead 10≥ug/dl
□ Other □ BTT □ CSHCN **1-800-642-9704**

**Prior Authorizations:**
**For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck**

**Follow Up/Next Visit:** □ 15 months of age □ Other

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

[1] Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.
**For assistance phone 844-HELP4WV (844-435-7498).**