

Screen Date \_\_\_\_\_

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

30 Month Form

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Wt \_\_\_\_\_ Ht \_\_\_\_\_ BMI \_\_\_\_\_ 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 or counselors and/or hospitalizations:

**Social Emotional Health/Interpersonal Trauma<sup>1</sup>**

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 \_\_\_\_\_

Gets along with other family members?  Yes  No

Social Emotional/Stress Indicators:  Check those that apply

Is there stress in the home?  Yes  No

Who do you call for help? \_\_\_\_\_

Has your child ever had a really scary or bad experience that they cannot forget?  Yes  No

Does your child have bad dreams or nightmares?  Yes  No

Has your child experienced an emotional loss?  Yes  No

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

Excessive television/video game/internet/cell phone use

Hours per day: \_\_\_\_\_ Who supervises usage? \_\_\_\_\_

**Developmental**

Developmental Surveillance & Screening completed: Standardized Screening Tool:

ASQ3 Other: \_\_\_\_\_

Results in chart/record  Yes  No

Comments: \_\_\_\_\_

**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

Date of last dental visit \_\_\_\_\_

Water source:  Public  Well  Tested

Fluoride  Yes  No

Current oral health issues \_\_\_\_\_

Nutrition:  Check those that apply

Normal eating habits \_\_\_\_\_

Vitamins \_\_\_\_\_

Normal elimination  Normal sleep patterns

Lead Risk:  Low risk  High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk:  Low risk  High risk

Tuberculosis Risk:  Low risk  High risk

Physical Examination:  = Normal limits

General Appearance

Neurological

Neck

Ocular Alignment

Oral Cavity/Throat

Pulse

Back

Reflexes

Eyes

Ears

Lung

Abdomen

Hips

Skin

Head

Red Reflex

Nose

Heart

Genitalia

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:

Referrals:  Developmental  Emotional  Dentist

Blood lead 10<sub>></sub>ug/dl  Other

BTT  CSHCN 1-800-642-9704

Birth To Three transition planning

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:  3 years of age  Other

\_\_\_\_\_  
Please Print Name of Facility or Clinician

\_\_\_\_\_  
Signature of Clinician/Title

<sup>1</sup> 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).