

Screen Date _____

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

9 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 Trauma¹

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 & Screening completed

Standardized Screening Tool:

ASQ3 Other: _____

Results in chart/record Yes No

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

Tooth eruption

Current oral health problems _____

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 _____

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 poisoning?

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, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, 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: Blood lead, if high risk

Referrals: Developmental Blood lead 10_≥ug/dl Other

RFTS 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: 12 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).