EPSDT/HealthCheck Health History Form 0-6 Years

Patient Name: _____ **Date of Birth:** _____ **Race/Ethnicity:** _____

Your Name: _____ **Relationship to Child:** _____ **Child's Age:** _____

Child's Health History

Pregnancy and Birth

Medical problems during pregnancy? _____

_____

In utero substance exposure? _____

Maternal Hep C exposure? _____

Where was the child born? _____

Delivered by: ☐ Vaginal ☐ C-section

Why C-section? _____

Birth Weight: _____ Birth Length: _____

High Birth Score: _____

☐ Full Term (≥ 37 weeks gestation)

☐ Preterm (≤ 36 weeks gestation)

☐ NICU stay: _____ weeks

Other problems in the newborn period? _____

Infancy and Childhood

Has your child ever been treated for or diagnosed with:

☐ Asthma or wheezing _____

☐ Pneumonia _____

☐ Lung problems _____

☐ Heart murmur _____

☐ Anemia _____

☐ Recurrent ear infections _____

☐ Hearing problems _____

☐ Vision or eye problems _____

☐ Urinary tract infections _____

☐ Stomach or digestive problems _____

☐ Seasonal allergies or eczema _____

☐ Seizures _____

☐ Broken bone(s) _____

☐ Learning disability _____

_____

☐ Depression/anxiety _____

☐ ADD/ADHD_____

☐ Other chronic medical problems _____

_____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including mental/behavioral health providers, your child is currently seeing and reason: _____

_____

Developmental

Do you have concerns about any of the following:

☐ Problems with sleeping or nightmares

☐ The way your child uses his/her arms, fingers or legs

☐ Speech problems

☐ Bad temper/breath holding/jealousy

☐ Nail biting/thumb sucking

☐ Vision (Are you concerned about your child's vision?)

☐ Hearing (Are you concerned about your child's hearing?)

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke/use tobacco products/e-cigarettes/ vaping? ☐ Yes ☐ No

TV hours per day _____

Internet/video games hours per day _____

Cell phone use hours per day _____

Is violence at home a concern? ☐ Yes ☐ No

Child's Health History

Medications

Current medications and dose: _____

_____

_____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

_____

_____

Nutrition and Feeding

☐ Has your child had any feeding/dietary problems? _____

_____

☐ Unexplained weight gain

☐ Unexplained weight loss

☐ Food allergies: _____

☐ Participates in WIC ☐ Yes ☐ No

Dental

☐ Problems with teeth or gums

☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Water source: ☐ City ☐ Well

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Postpartum depression	☐			☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed mental condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐

Other: _____

_____

Other Concerns:_____

_____

_____

Reviewed by: _____

Date: _____

West Virginia Department of HEALTH

EPSDT/HealthCheck Health History Form 7-20 Years

Patient Name: _____ **Date of Birth:** _____ **Race/Ethnicity:** _____

Your Name: _____ **Relationship to Child:** _____ **Child's Age:** _____

Child's Health History

Childhood

Has your child ever been treated for or diagnosed with:

- ☐ Asthma or wheezing _____
- ☐ Pneumonia _____
- ☐ Lung problems _____
- ☐ Heart murmur _____
- ☐ Anemia _____
- ☐ Recurrent ear infections _____
- ☐ Hearing problems _____
- ☐ Vision or eye problems _____
- ☐ Urinary tract infections _____
- ☐ Stomach or digestive problems _____
- ☐ Seasonal allergies or eczema _____
- ☐ Seizures _____
- ☐ Broken bone(s) _____
- ☐ Learning disability _____

_____

- ☐ Depression/anxiety _____
- ☐ ADD/ADHD _____
- ☐ Other chronic medical problems: _____

_____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including mental/behavioral health providers, your child is currently seeing and reason: _____

_____

_____

Developmental/Behavior

Do you have concerns about any of the following:

- ☐ Problems with sleeping or nightmares
- ☐ The way your child uses his/her arms, fingers or legs
- ☐ Speech problems
- ☐ Bad temper/breath holding/jealousy
- ☐ Nail biting/thumb sucking
- ☐ Bedwetting (after 6 years)
- ☐ Vision (Are you concerned about your child's vision?)
- ☐ Hearing (Are you concerned about your child's hearing?)

Does your child have problems with:

- ☐ School attendance
- ☐ Getting along with other children including siblings
- ☐ Getting along with parents or other adults
- ☐ Threaten to harm self, others or animals
- ☐ Sexual acting out
- ☐ Destroying property
- ☐ Drug use, alcohol use, smoking, e-cigarettes and/or vaping

Puberty

Concerns about:

- ☐ Body changes
- ☐ Sexual activity
- ☐ Sexually transmitted infection ***(i.e.,Hepatitis B, Hepatitis C, HIV, etc.)***
- ☐ Discharge: vaginal or penis
- ☐ Contraception

For Girls:

Age of first menstrual period? _____

Child's Health History

Medications

Current medications and dose: _____

_____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

_____

Nutrition

☐ Has your child had any dietary problems? _____

_____

- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Food allergies: _____

Dental

- ☐ Problems with teeth or gums
- ☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Sudden Cardiac Arrest (11 -20 years)

- ☐ Fainted, passed out or had an unexplained seizure suddenly and without warning
- ☐ Experienced exercise-related chest pain or shortness of breath

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke/use tobacco products/e-cigarettes/ vaping? ☐ Yes ☐ No

TV hours per day _____

Internet/video games hours per day _____

Cell phone/social media hours per day _____

Is violence at home a concern? ☐ Yes ☐ No

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed Mental Condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐
Unexpected Sudden Death	☐	☐	☐	☐
Pacemaker/Imp. Defibrillator	☐	☐	☐	☐

Other _____

Other Concerns:_____

Reviewed by: _____

Date: _____

Screen Date_____

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

Newborn to 1 Week Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

In utero substance exposure ☐ Yes ☐ No _____
Maternal Hep C exposure ☐ Yes ☐ No _____
Gestational age_____ Maternal labs_____
Complications_____
Birth history ☐ NSVD ☐ C-section Breech ☐ Yes ☐ No
Birth weight_____ Discharge weight_____
High birth score ☐ Yes ☐ No _____
Newborn metabolic screen ☐ NL
Newborn bilirubin screen ☐ NL
Newborn critical congenital heart disease pulse oximetry _____
Newborn hearing screen ☐ Pass ☐ Fail ☐ Pending ☐ Retest

_____

Hepatitis B Risk *(See Periodicity Schedule for Risk Factors)*
☐ Low risk ☐ High risk

Psychosocial/Behavioral

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? _____

_____

_____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____

_____

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_____

_____

Does your child mind being held by other people?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child cry a lot?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much
Is your child fussy or irritable?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to comfort your child?
☐ Not at all ☐ Somewhat ☐ Very Much
Is it hard to put your child to sleep?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to get enough sleep because of your child?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have trouble staying asleep?
☐ Not at all ☐ Somewhat ☐ Very much

_____
_____
_____
_____
_____
_____
_____
_____
_____

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child has periods of wakefulness ☐ Child looks at and studies you when awake ☐ Child looks in your eyes when being held ☐ Child calms when picked up ☐ Child responds differently to soothing touch and alerting touch
Verbal Language ☐ Child communicates discomfort through crying, facial expressions and body movements ☐ Child moves or calms to your voice
Gross Motor ☐ Child moves in response to visual or auditory stimuli ☐ Child moves arms and legs symmetrically and reflexively when startled ☐ Child lifts head briefly when on stomach and can turn it to the side
Fine Motor ☐ Child keeps hands in fist ☐ Child automatically grasps others' fingers or objects

_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
Do you think your child sees okay? ☐ Yes ☐ No

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Place on back to sleep_____

_____

Continue on page 2

Name______________________________ DOB__________________ Age____________ Sex: ☐ M ☐ F

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 ____________
Ears ☐ N ☐ Abn ____________
Nose ☐ N ☐ Abn ____________
Oral Cavity/Throat ☐ N ☐ Abn ____________
Lung ☐ N ☐ Abn ____________
Heart ☐ N ☐ Abn ____________
Pulses ☐ N ☐ Abn ____________
Abdomen ☐ N ☐ Abn ____________
Umbilical cord ☐ N ☐ Abn ____________
Genitalia ☐ N ☐ Abn ____________
Back ☐ N ☐ Abn ____________
Hips ☐ N ☐ Abn ____________
Extremities ☐ N ☐ Abn ____________
Jaundice ☐ Yes ☐ No
Possible Signs of Abuse/Neglect ☐ Yes ☐ No
Concerns and/or questions ____________

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Parental/Family Health and Well-Being, Newborn Behavior and Care, Nutrition and Feeding, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other ____________

Referrals ☐ 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**

Medical Necessity
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 ☐ 1 month of age ☐ 2 months of age
☐ Other____________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

West Virginia Department of HEALTH

Screen Date_____

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

By 1 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

Birth weight_____ Discharge weight_____

High birth score ☐ Yes ☐ No _____

Newborn metabolic screen ☐ NL ☐ Results in child's record

Newborn bilirubin screen ☐ NL ☐ Results in child's record

Newborn critical congenital heart disease pulse oximetry _____

☐ Results in child's record

Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____

☐ Results in child's record

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

_____

Psychosocial/Behavioral

What is your family's living situation?_____

_____

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? _____

_____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, 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 (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 (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ Child looks at you and follows you with his/her eyes ☐ Child has self-comforting behaviors, such as bringing hands to mouth ☐ Child becomes fussy when bored ☐ Child calms when picked up or spoken to

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

Gross Motor ☐ Child moves both arms and legs together ☐ Child can hold chin up when on stomach

Fine Motor ☐ Child can open fingers slightly when at rest

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____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_____

***Tuberculosis Risk** ☐ Low risk ☐ High risk
***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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	_____
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/Neglect ☐ Yes ☐ No

_____
_____
_____

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Parental/Family Health and Well-Being, Infant Behavior and Development, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ TB skin test *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other

_____
_____

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**

Medical Necessity
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

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

West Virginia Department of HEALTH

Screen Date_____

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

2 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

Newborn metabolic screen ☐ NL ☐ Results in child's record

Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____

☐ Results in child's record

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

_____

_____

Psychosocial/Behavioral

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? _____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Sever

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 (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ Child smiles responsively ☐ Child makes sounds that let you know if he/she is happy

Verbal Language (Expressive and Receptive) ☐ Child makes short cooing sounds

Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position

Fine Motor ☐ Child can open and shut hands ☐ Child can briefly bring hands together

_____

_____

Continue on page 2

Name______________________________ DOB____________________ Age__________ Sex: ☐ M ☐ F

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____________ Frequency__________

☐ Formula ____________

☐ Normal elimination____________

☐ Normal sleeping patterns____________

☐ Place on back to sleep____________

☐ Sleeps 3 to 4 hours at a time____________

Concerns and/or questions____________

____

Hepatitis B Risk *(See Periodicity Schedule for Risk Factors)*

☐ 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	____________
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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Parental/Family Health and Well-Being, Infant Behavior and Development, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

____

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Hepatitis B Screen (HBsAG) *(if high risk)*

☐ Other ____________

____

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**

Medical Necessity

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

West Virginia Department of HEALTH

Screen Date_____

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

4 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

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

_____

_____

Psychosocial/Behavioral

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

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 (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check those that apply)*

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

_____

_____

_____

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____ Frequency_____
☐ Formula _____
☐ Juice ☐ Water
☐ Has started solid foods ☐ Normal eating habits
☐ Vitamins
☐ Normal elimination_____
☐ Normal sleeping patterns_____
☐ Place on back to sleep_____

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

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Infant Behavior and Development, Oral Health, Nutrition and Feeding, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Hemoglobin/hematocrit *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other
_____
_____

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**

Medical Necessity

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 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

Screen Date_____

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

6 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

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

_____

_____

Psychosocial/Behavioral

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

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 (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

_____

_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in <u>any</u> of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

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

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____

***Lead Risk**	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
* **Hepatitis B Risk**	☐ Low risk	☐ High risk

See Periodicity Schedule for Risk Factors

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/Neglect ☐ Yes ☐ No

_____

_____

_____

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further Information: https://brightfutures.aap.org)*

Social Determinants of Health, Infant Behavior and Development, Oral Health, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

_____

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Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Blood lead *(if high risk) (enter into WVSIIS)*

☐ TB skin test *(if high risk)*

☐ Hepatitis B Screen (HBsAG) *(if high risk)*

☐ Other

_____

_____

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**

Medical Necessity

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 ☐ 9 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

Screen Date_____

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

9 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

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_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

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

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 _____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____
☐ Place on back to sleep_____

***Lead Risk** ☐ Low risk ☐ High risk
* **Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

_____
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Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Infant Behavior and Development, Discipline, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other

_____
_____

Referrals

☐ 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**

Medical Necessity

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 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

Screen Date_____

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

12 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ Yes ☐ No _____

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

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 exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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_____

_____

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_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check that 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_____

_____

_____

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

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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
☐ Breastfeeding - 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_____

***Anemia Risk (Hemoglobin/Hematocrit)**
Hemoglobin/hematocrit required at 12 months

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

***Tuberculosis Risk** ☐ Low risk ☐ High risk

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Establishing Routines, Feeding and Appetite Changes, Establishing a Dental Home, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

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Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(required at 12 months)*
☐ Blood lead *(required at 12 months) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other
_____
_____

Referrals
☐ Developmental ☐ **Dental** ☐ Blood lead ≥5ug/dl
☐ 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**

Medical Necessity
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

West Virginia Department of HEALTH

Screen Date_____

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

15 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

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 exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

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_____

_____

Baby Pediatric Symptom Checklist (BPSC)

Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ *Check one for each question)*

Does your child have a hard time being with people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time in new places?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time with change?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child mind being held by other people?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 1 score _____

Subscale 2 (✓ *Check one for each question)*

Does your child cry a lot?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have a hard time calming down?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is your child fussy or irritable?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to comfort your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 2 score _____

Subscale 3 (✓ *Check one for each question)*

Is it hard to keep your child on a schedule or routine?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to put your child to sleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Is it hard to get enough sleep because of your child?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Does your child have trouble staying asleep?

☐ Not at all (0) ☐ Somewhat (1) ☐ Very much (2)

Subscale 3 score _____

Developmental

Developmental Surveillance (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can prodeclarative 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_____

_____

_____

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

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____

***Anemia Risk (Hemoglobin/Hematocrit)** ☐ Low risk ☐ High risk
***Lead Risk** ☐ Low risk ☐ High risk
***Hepatitis B Risk** ☐ Low risk ☐ High risk
****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No
_____
_____

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Communication and Social Development, Sleep Routines and Issues, Temperament, Development, Behavior, and Discipline, Healthy Teeth, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

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Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

Referrals
☐ Developmental ☐ Dental
☐ 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**

Medical Necessity
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

West Virginia Department of HEALTH

Screen Date_____

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

18 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

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 exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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_____

_____

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_____

_____

Does your child seem nervous or afraid?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?

☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?

☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

General Health

☐ Growth plotted on growth chart

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

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

Oral Health

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_____

Hours of sleep each night?_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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

***Lead Risk** ☐ Low risk ☐ High risk

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Temperament, Development, Toilet Training, Behavior and Discipline, Communication and Social Development, Television Viewing and Digital Media, Healthy Nutrition, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment

☐ Well Child ☐ Other Diagnosis

Immunizations

☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs

☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____

Referrals

☐ Developmental ☐ Dental
☐ 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**

Medical Necessity

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 ☐ 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

Screen Date_____

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

24 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height _____ BMI_____ HC_____ Pulse_____ BP (*optional*)_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____

_____

_____

Psychosocial/Behavioral

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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_____

_____

Does your child seem nervous or afraid?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?
☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?
☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to know what your child needs?
☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

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

_____

_____

_____

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

_____

_____

_____

General Health

☐ Growth plotted on growth chart

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

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

Oral Health

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 _____

Continue on page 2

Name______________________________ DOB____________________ Age____________ Sex: ☐ M ☐ F

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?____________________

***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

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Temperament and Behavior, Assessment of Language Development, Toilet Training, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

____

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(required at 24 months) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(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**

Medical Necessity
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

West Virginia Department of HEALTH

Screen Date_____

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

30 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster child _____ ☐ Kinship placement_____ ☐ Child with special health care needs_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

In utero substance exposure ☐ Yes ☐ No _____

Child currently receiving mental/behavioral health services?

☐ Yes ☐ No _____

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

_____

_____

Psychosocial/Behavioral

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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_____

_____

_____

Does your child seem nervous or afraid?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have trouble playing with other children?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?

☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to know what your child needs?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to get your child to obey you?

☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

_____

_____

_____

_____

General Health

☐ Growth plotted on growth chart

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

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

Oral Health

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?_____

_____

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

***Anemia Risk (Hemoglobin/Hematocrit)** ☐ Low risk ☐ High risk
***Lead Risk** ☐ Low risk ☐ High risk
***Tuberculosis Risk** ☐ Low risk ☐ High risk
***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Temperament and Behavior, Assessment of Language Development, Toilet Training, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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)*
☐ Hepatitis B Screen (HBsAG) *(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

Medical Necessity
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

West Virginia Department of HEALTH

Screen Date_____

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

3 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement _____ ☐ 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

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

☐ Concerns about child's speech, learning, or motor skills
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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
☐ **Family health history reviewed** _____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

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 _____
Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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_____
_____

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance *(✓ Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- ☐ Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____
_____
_____
_____

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?_____

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Lead Risk**	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Hepatitis B Risk**	☐ Low risk	☐ High risk

****See Periodicity Schedule for Risk Factors***

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/Neglect ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____
_____

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Playing with Siblings and Peers, Encouraging Literacy Activities, Promoting Healthy Nutrition and Physical Activity, and Safety
☐ Discussed ☐ Handouts Given

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)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other
_____
_____

Referrals
See page 1, school requirements

Medical Necessity
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

West Virginia Department of HEALTH

Screen Date_____

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

4 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement _____ ☐ 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
20 db@ ☐ UTO *(retest in 6 months)*
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

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 person with at least 3 body parts ☐ 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_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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
☐ **Family health history reviewed** _____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

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 _____
_____

Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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_____
_____

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- ☐ Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____
_____
_____
_____

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?_____

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Lead Risk**	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Dyslipidemia Risk**	☐ Low risk	☐ High risk
***Hepatitis B Risk**	☐ Low risk	☐ High risk

See Periodicity Schedule for Risk Factors

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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, School Readiness, Developing Healthy Nutrition and Personal Habits, Media Use, and Safety
☐ Discussed ☐ Handouts Given

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 *(if high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

Referrals

See page 1, school requirements

Medical Necessity

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

West Virginia Department of HEALTH

Screen Date_____

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

5 and 6 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement _____☐ 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 *(5 years, apply every 3 to 6 months)*
☐ 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

Developmental Surveillance (✓*Check those that apply)*
☐ Child can balance 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 speech, learning, or motor skills
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

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 _____
_____
Child's grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

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_____
_____

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Does not achieve satisfactorily due to poor attention or high activity level; special accommodations are needed or implemented
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ On more than one occasion, committed acts that would be considered delinquent if a child were older (e.g., vandalism, defacing property, threatening aggression, shoplifting other than minor items such as candy)
- ☐ Repeatedly and intentionally plays with fire such that damage to property or person could result
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Extremely tense or fearful (e.g., overreacts to sounds and noises)
- ☐ Persistent self-criticism or feelings of worthlessness
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Extremely limited in expressing self verbally and this is not due to any know physical or sensory disability, speech impediment or lack of familiarity with English
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____

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?_____

*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
***Hepatitis B Risk**	☐ Low risk	☐ High risk

**See Periodicity Schedule for Risk Factors*

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 /Neglect ☐ Yes ☐ No

_____
_____
_____

Age Appropriate Health Education/Anticipatory Guidance (*Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Developmental and Mental Health, School, Physical Growth and Development and Safety
☐ Discussed ☐ Handouts Given

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)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

Referrals

See page 1, school requirements

Medical Necessity:

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

Screen Date_____

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

7 and 8 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement _____☐ 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 WVSIIS

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 child's speech, learning, 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

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

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

Exposure to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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_____
_____
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

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_____
_____

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance *(✓ Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Does not achieve satisfactorily due to poor attention or high activity level; special accommodations are needed or implemented
- ☐ Inappropriate behavior resulting in disruption to others
- ☐ Deliberate damage to home
- ☐ On more than one occasion, committed acts that would be considered delinquent if child were older (e.g., vandalism, defacing property, threatening aggression, shoplifting other than minor items such as candy)
- ☐ Repeatedly and intentionally plays with fire such that damage to property or person could result
- ☐ Often mean or nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play; would rather be alone
- ☐ Extremely tense or fearful (e.g., overreacts to sounds or noises)
- ☐ Persistent self-criticism or feeling of worthlessness
- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Pre-occupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources.

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?_____

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Dyslipidemia Risk**	☐ Low risk	☐ High risk
***Hepatitis B Risk**	☐ Low risk	☐ High risk

See Periodicity Schedule for Risk Factors

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	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

_____
_____
_____
_____

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Developmental and Mental Health, School, Physical Growth and Development, and Safety
☐ Discussed ☐ Handouts Given

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)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

Referrals

See page 1, school requirements

Medical Necessity:

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

Screen Date_____

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

9 and 10 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement_____ ☐ 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

☐ **Family health history reviewed** _____

_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No

_____

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

_____

_____

Psychosocial/Behavioral

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

Exposure to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ 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

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

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

Concerns about speech, learning, social or motor skills _____

_____

Concerns about depression and/or anxiety_____

_____

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 (0) ☐ 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 (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

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_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die

☐ Frequently mean to other people or animals

☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)

☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)

☐ Frequent use of profane, vulgar, or curse words to household members

☐ Deliberate damage to home

☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)

☐ Marked changes in moods that are generally intense and abrupt

☐ Friendships change to mostly substance users

☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes

☐ Currently at risk of confinement because of frequent or serious violations of law

☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

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

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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

***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

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Development and Mental Health, School, Physical and Growth Development, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Fasting lipoprotein (*once between 9 and 11 years and/or high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____

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

Medical Necessity
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

Screen Date_____

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

11, 12, 13 and 14 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement_____ ☐ 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 WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ 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

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about speech, learning, social and/or motor skills
_____
_____

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 Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
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
☐ **Family health history reviewed** _____
_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

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
☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes/Vaping ☐ *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
Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ 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 _____
_____

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 (0) ☐ 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 (0) ☐ 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 (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)
Feeling down, depressed, or hopeless: ☐ Not at all (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals
- ☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
- ☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
- ☐ Frequent use of profane, vulgar, or curse words to household members
- ☐ Deliberate damage to home
- ☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
- ☐ Marked changes in moods that are generally intense and abrupt
- ☐ Friendships change to mostly substance users
- ☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Currently at risk of confinement because of frequent or serious violations of law
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Suicide Risk Screen

In the past few weeks, have you wished you were dead?
☐ Yes ☐ No
In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
Have you ever tried to kill yourself? ☐ Yes ☐ No

If patient answers Yes to any of the above, or refuses to answer, they are considered a positive screen. Ask the following acuity question:

Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
(Yes, imminent risk identified. Patient required a STAT safety/full mental health evaluation.)

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?_____

***Anemia Risk** (Hemoglobin/Hematocrit)	☐ Low risk	☐ High risk
***Tuberculosis Risk**	☐ Low risk	☐ High risk
***Dyslipidemia Risk** Fasting lipoprotein required once between 9 and 11 years	☐ Low risk	☐ High risk
***STI Risk**	☐ Low risk	☐ High risk
***HIV Risk**	☐ Low risk	☐ High risk
***Hepatitis B Risk**	☐ Low risk	☐ High risk

See Periodicity Schedule for Risk Factors

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	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

If female:

LMP_____	☐ Regular	☐ Irregular
Bleeding	☐ Normal	☐ Heavy
Cramping	☐ No	☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

_____
_____
_____

Sudden Cardiac Arrest (SCA) Evaluation

- ☐ Fainted, passed out or had an unexplained seizure suddenly and without warning.
- ☐ Experienced exercise-related chest pain or shortness of breath.
- ☐ Had an immediate family member or distant relative die of heart problems or unexpected sudden death before age 50.
- ☐ Related to anyone with hypertrophic obstructive cardiomyopathy (HCM), Marfan syndrome, Arrhythmogenic cardiomyopathy (ACM), long QT syndrome (LQTS), short QT syndrome, BrS (baroreflex sensitivity) or Catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator.

(Positive response or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist.)

Age Appropriate Health Education/Anticipatory Guidance (*Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determents of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child Visit ☐ 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)*
- ☐ Hepatitis B Screen (HBsAG) *(if high risk)*
- ☐ Other _____

Referrals
See page 1, school requirements

☐ Pediatric Cardiologist *(based on SCA evaluation above)*
☐ Mental health evaluation

Medical Necessity:
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 ☐ 15 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

West Virginia Department of HEALTH

Screen Date_____

West Virginia Department of Health
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 **Race/Ethnicity**_____

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement_____☐ 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 WVSIIS

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 speech, learning, social and/or motor skills_____
_____

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 Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

_____
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
☐ **Family health history reviewed** _____
_____
Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

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? _____
_____

☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes/Vaping ☐ *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
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 _____
_____

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 (0) ☐ 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 (0) ☐ 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 (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)
Feeling down, depressed, or hopeless: ☐ Not at all (0)
☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Continue on page 2

West Virginia Department of HEALTH

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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_____
_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
☐ Frequently mean to other people or animals
☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
☐ Frequent use of profane, vulgar, or curse words to household members
☐ Deliberate damage to home
☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
☐ Marked changes in moods that are generally intense and abrupt
☐ Friendships change to mostly substance users
☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
☐ Currently at risk of confinement because of frequent or serious violations of law
☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Suicide Risk Screen

In the past few weeks, have you wished you were dead?
☐ Yes ☐ No
In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
Have you ever tried to kill yourself? ☐ Yes ☐ No

If patient answers Yes to any of the above, or refuses to answer, they are considered a positive screen. Ask the following acuity question:

Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
(Yes, imminent risk identified. Patient required a STAT safety/full mental health evaluation.)

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?_____

***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 **20** years*

***Hepatitis B Risk** ☐ Low risk ☐ High risk

See Periodicity Schedule for Risk Factors

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	_____
Genitalia	☐ N ☐ Abn	_____
Back	☐ N ☐ Abn	_____
Hips	☐ N ☐ Abn	_____
Extremities	☐ N ☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Sudden Cardiac Arrest (SCA) Evaluation

☐ Fainted, passed out or had an unexplained seizure suddenly and without warning.
☐ Experienced exercise-related chest pain or shortness of breath.
☐ Had an immediate family member or distant relative die of heart problems or unexpected sudden death before age 50.
☐ Related to anyone with hypertrophic obstructive cardiomyopathy (HCM), Marfan syndrome, Arrhythmogenic cardiomyopathy (ACM), long QT syndrome (LQTS), short QT syndrome, BrS (baroreflex sensitivity) or Catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator.
(Positive response or an abnormal ECG should prompt further investigation that may include referral to a pediatric cardiologist.)

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety
☐ Discussed ☐ Handouts Given

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 **20** years, if sexually active and/or high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements
☐ Pediatric Cardiologist *(based on SCA evaluation above)*
☐ Mental health evaulation

Medical Necessity
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
☐ 18 years of age ☐ Other_____

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

See page 1, school requirements for required signature

West Virginia Department of HEALTH

Screen Date_____

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

18, 19 and 20 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

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

☐ **Family health history reviewed** _____

_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No

_____

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

_____

_____

Psychosocial/Behavioral

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 _____

_____

☐ *Tobacco use ☐ Cigarettes # per day_____

☐ E-Cigarettes/Vaping ☐ *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 _____

_____

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 (0) ☐ 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 (0) ☐ 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 (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)

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/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
☐ Frequently mean to other people or animals
☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
☐ Frequent use of profane, vulgar, or curse words to household members
☐ Deliberate damage to home
☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
☐ Marked changes in moods that are generally intense and abrupt
☐ Friendships change to mostly substance users
☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
☐ Currently at risk of confinement because of frequent or serious violations of law
☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Suicide Risk Screen

In the past few weeks, have you wished you were dead? ☐ Yes ☐ No

In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No

In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No

Have you ever tried to kill yourself? ☐ Yes ☐ No

If patient answers Yes to any of the above, or refuses to answer, they are considered a positive screen. Ask the following acuity question:

Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
(Yes, imminent risk identified. Patient required a STAT safety/full mental health evaluation.)

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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

***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 **20** years*

***Hepatitis B Risk** ☐ Low risk ☐ High risk

****See Periodicity Schedule for Risk Factors***

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	_____
Genitalia	☐ N ☐ Abn	_____
Back	☐ N ☐ Abn	_____
Hips	☐ N ☐ Abn	_____
Extremities	☐ N ☐ Abn	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Sudden Cardiac Arrest (SCA) Evaluation

☐ Fainted, passed out or had an unexplained seizure suddenly and without warning.
☐ Experienced exercise-related chest pain or shortness of breath.
☐ Had an immediate family member or distant relative die of heart problems or unexpected sudden death before age 50.
☐ Related to anyone with hypertrophic obstructive cardiomyopathy (HCM), Marfan syndrome, Arrhythmogenic cardiomyopathy (ACM), long QT syndrome (LQTS), short QT syndrome, BrS (baroreflex sensitivity) or Catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator.

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Social Determinants of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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 **20** years, if sexually active and/or high risk)*
☐ Hepatitis C Virus Test *(once between 18 and **20** years)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other _____
_____

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 Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Transition to adult-oriented health care/medical home
☐ Cardiologist *(based on SCA evaluation)*
☐ Mental health evaulation

Medical Necessity
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**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

West Virginia Department of HEALTH

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

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