EPSDT/HealthCheck Health History Form 0-6					0-6 Years	
Patient Name:	Date of Birth:	R	ace/Ethr	nicity: _		
Your Name: Re	elationship to C	Child:		(Child's A	Age:
Child's Health History		CI	nild's Hea	alth Hist	ory	
Pregnancy and Birth		Adications				
Medical problems during pregnancy?	(Current medications and c	lose:			
In utero substance exposure?	-					
Maternal Hep C exposure?		/itamins:				
Where was the child born?		lerbs/home remedies:				
Delivered by: Vaginal C-section		Over the counter:				
Why C-section? Birth Weight:	A	Allergies/reactions to me	edications	or vacci	nes:	
High Birth Score: Birth Length						· · · · · · · · · · · · · · · · · · ·
\Box Full Term (\geq 37 weeks gestation)						
\Box Preterm (\leq 36 weeks gestation)	N	Nutrition and Feeding				
□ NICU stay: weeks	E	Has your child had any	feeding/di	etary prob	olems?	
Other problems in the newborn period?	_					
		Unexplained weight ga	in			
Infancy and Childhood		Unexplained weight los	s			
Has your child ever been treated for or diagnosed with:		Food allergies:				
Asthma or wheezing		□ Participates in WIC □		No		
Pneumonia		Dental				
Lung problems	_		aumo			
Heart murmur		 Problems with teeth or Bad breath 	guns			
Anemia			hu a dantia	+2 🗆 Va		
Recurrent ear infections	u	las your child been seen				
Hearing problems		f so, date of last exam:	ntiat?			·····
Vision or eye problems		Vhy did he/she see the de Vater source: □ City □				·····
Urinary tract infections	V		vven			
Stomach or digestive problems		Fa	mily Med	ical Hist	ory	
Seasonal allergies or eczema	C	Do any family members	have any	v of the f	ollowing	conditions?
Seizures	(Condition		-	-	Grandparent
Broken bone(s)	A	Asthma				
Learning disability	A	nemia				
	F	Blood disorder				
Depression/anxiety	(Cancer				
ADD/ADHD	F	leart disease				
Other chronic medical problems		leart attack				
		ligh cholesterol				
Has your child ever been hospitalized?	F	ligh blood pressure				
□ No □ Yes Why?		Stroke				
Previous surgeries:	r	Diabetes				
Please list any specialists, including mental/behavioral health	h providers, т	hyroid disease				
your child is currently seeing and reason:		Kidney disease				
		Seizures				
Developmental		Postpartum depression				
Do you have concerns about any of the following:		Depression/anxiety				
Problems with sleeping or nightmares		Diagnosed mental condition				
 Froblems with sleeping of highlinales The way your child uses his/her arms, fingers or legs 		Drug and/or alchol use				
□ The way your child uses his/her arms, hingers of legs □ Speech problems		Other:				_
□ Bad temper/breath holding/jealousy						
 Dad temper/bleatinnoiding/jealousy Nail biting/thumb sucking 	-					
 Vision (Are you concerned about your child's vision?) 	ć	Other Concerns:				
 Hearing (Are you concerned about your child's hearing?) 						
	-					
Exposure/Habits	-					
Any concerns about lead exposure (old home, plumbing,						
peeling paint)?	□ No F	Reviewed by:				

peeling paint)?	Yes	🗆 No
Do any household members smoke/u	ise 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

Date: _____

West Virginia Department of HEALTH

EPSDT/HealthCheck Health History Form

EPSDT/Hea	althCheck Healt	th History Form	า		7-2	0 Years
Patient Name:	Date of Bi	rth: F	Race/Eth	nnicity: _		
Your Name: F	Relationship to Child	:		_ Child'	s Age: _	
Child's Health History						
Childhood		<u>Child</u>	l's Healt	h Histor	У	
Has your child ever been treated for or diagnosed with:		cations				
Asthma or wheezing	Curre	ent medications and dos	e:			
□ Pneumonia						
Lung problems	vitan	nins:				
Heart murmur	TIELD	s/home remedies:				
Anemia	0101	the counter:				
Recurrent ear infections	Aller	gies/reactions to medi	cations	or vaccine	es:	
Hearing problems						
Vision or eye problems	Nutr	tion				
Urinary tract infections	——— ПН	as your child had any di	etary prol	olems?		
Stomach or digestive problems		ao your onna naa ariy a	otary pro			
Seasonal allergies or eczema		nexplained weight gain				
Seizures		nexplained weight loss				
Broken bone(s)	D E	ood allergies:				
Learning disability						
	D	al				
Depression/anxiety		roblems with teeth or gu	ms			
ADD/ADHD		ad breath				
Other chronic medical problems:		your child been seen by	a dentist	?	Yes	🗆 No
		date of last exam:				
Has your child ever been hospitalized?	Why	did he/she see the dent	ist?			
□ No □ Yes Why?						
Previous surgeries:	Sudo	len Cardiac Arrest (11				
Please list any specialists, including mental/behavioral healt	h providers, 🛛 🗍 F	ainted, passed out or ha	ad an une	explained s	seizure sud	denly and
your child is currently seeing and reason:		ithout warning				
		xperienced exercise-rel	ated ches	st pain or s	shortness c	of breath
Developmental/Behavior	•	osure/Habits concerns about lead exp	osure (ol	d home, p	lumbing,	
Do you have concerns about any of the following:		ng paint)?			□ Yes	🗆 No
 Problems with sleeping or nightmares 	Do a	ny household members	smoke/us	se tobacco	products/	e-cigarettes/
□ The way your child uses his/her arms, fingers or legs	vapir	ig?			□ Yes	🗆 No
□ Speech problems	TV h	ours per day				
□ Bad temper/breath holding/jealousy	Inter	net/video games hours p	oer day _			
□ Nail biting/thumb sucking		phone/social media hour				
□ Bedwetting (after 6 years)	ls vic	lence at home a concer	n?		Yes	🗆 No
□ Vision (Are you concerned about your child's vision?)						
□ Hearing (Are you concerned about your child's hearing?))	<u>Fami</u>	ily Medic	al History	<u>/</u>	
Does your child have problems with:	Do a	ny family members have				
□ School attendance				Father	-	Grandparent
	Asth					
 Getting along with other children including siblings Getting along with parents or other adults 	Anen					
□ Getting along with parents or other adults	Cano	d disorder er				
□ Threaten to harm self, others or animals		t disease				
Sexual acting out Destroying property		t attack				
Destroying property	High	cholesterol				
Drug use, alcohol use, smoking, e-cigarettes and/or vapi	na	blood pressure				
Puberty	Strok	e				
Concerns about:	Diab					
Body changes		bid disease				
□ Sexual activity		ey disease				
Sexually transmitted infection (i.e., Hepatitis B, Hepatitis	C, HIV, etc.) Seizu	ession/anxiety				
□ Discharge: vaginal or penis	Бері	nosed Mental Condition				
	0	and/or alchol use				
For Girls:	•	pected Sudden Death				
Age of first menstrual period?	Pace	maker/Imp. Defibrillator				
· · · · · · · · · · · · · · · · · · ·		r		<u> </u>		
n West Virginia	Othe	r Concerns:				
Department of	Revi	ewed by:				
HEALTH WVDH/BPH/OMCFH/HC 05.0		:				

-	creening, Diagnosis, and Treatment (EPSDT) HealthCheck Pr	-
Name		
Weight Length Weight for Length	HC Pulse BP (optional)	Resp Temp Pulse Ox (optional)
Allergies D NKDA		
Current meds Done		
Foster child K	inship placement C	Child with special health care needs
Accompanied by Parent Grandparent Foster parent F	Foster organization	Dther
Medical History	Child exposed to Cigarettes E-Cigarettes/Vaping Alcoho	
□ Family health history reviewed	Drugs (prescription or otherwise)	
Concerns and/or questions	How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe	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
In utero substance exposure Yes No	What kind of stress? (✓ Check those that apply) □ Relationships (partner, family and/or friends) □ School/work	picked up Child responds differently to soothing touch and alerting touch
Maternal Hep C exposure	\Box Child care \Box Drugs \Box Alcohol \Box Violence/abuse (physical,	Verbal Language □ Child communicates discomfort through crying, facial expressions and body movements □ Child moves or
Gestational age Maternal labs Complications	emotional and/or sexual)	of calms to your voice
Birth history □ NSVD □ C-section Breech □ Yes □ No	support/help \Box Financial/money \Box Emotional loss \Box Health	Gross Motor Grild moves in response to visual or auditory
Birth weight Discharge weight	insurance D Other	— stimuli □ Child moves arms and legs symmetrically and
High birth score □ Yes □ No		— reflexively when startled □ Child lifts head briefly when on
Newborn metabolic screen DNL		stomach and can turn it to the side
Newborn bilirubin screen	Does your child mind being held by other people?	Fine Motor Child keeps hands in fist Child automatically
Newborn critical congenital heart disease pulse oximetry	□ Not at all □ Somewhat □ Very much Does your child cry a lot?	grasps others' fingers or objects
Newborn hearing screen □ Pass □ Fail □ Pending □ Retest	□ Not at all □ Somewhat □ Very much	
	Does your child have a hard time calming down?	
Hepatitis B Risk (See Periodicity Schedule for Risk Factors)	□ Not at all □ Somewhat □ Very much	
Low risk High risk	Is your child fussy or irritable?	
Psychosocial/Behavioral	□ Not at all □ Somewhat □ Very much	General Health
What is your family's living situation?	Is it hard to comfort your child? □ Not at all □ Somewhat □ Very Much	□ Growth plotted on growth chart
	Is it hard to put your child to sleep?	Do you think your child sees okay? □ Yes □ No
Do you have the things you need to take care of your baby (crib, car	□ Not at all □ Somewhat □ Very much	Oral Health
seat, diapers, etc.)?	Is it hard to get enough sleep because of your child?	Water source:
	□ Not at all □ Somewhat □ Very much	
De you have concerne about meeting basis family needs daily and/or	Does your child have trouble staying asleep?	Nutrition/Sleep
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No	□ Not at all □ Somewhat □ Very much	Breastfeeding - Frequency
		D Bottle feeding - Amount Frequency
		□ Formula □ Normal elimination
Who do you contact for help and/or support?		□ Place on back to sleep
		—
Are you and/or your partner working outside home? Yes No Child care plans?		Continue on page 2
		West Virginia Department of HEALT

Name		DOB	Age Sex: 🗆 M 🗆 F
Physical Exami	nation (N=Normal, Abn=Abnormal)	Questions/Concerns/Notes	Plan of Care
General Appearance	e 🗆 N 🗆 Abn		Assessment
Skin	□ N □ Abn	-	Well Child Other Diagnosis
Neurological	□ N □ Abn	-	
Reflexes	□ N □ Abn	-	
Head	□ N □ Abn	-	Immunizations
Fontanelles	□ N □ Abn	-	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Neck	□ N □ Abn	-	
Eyes	□ N □ Abn	-	
Red Reflex	□ N □ Abn	-	Labs
		-	Hepatitis B Screen (HBsAG) (if high risk)
Ears		_	□ Other
Nose			
Oral Cavity/Throat	□ N □ Abn	_	
Lung	□ N □ Abn	-	
Heart	□ N □ Abn	_	
Pulses	□ N □ Abn	_	Referrals Developmental
Abdomen	□ N □ Abn	_	Other
Umbilical cord	□ N □ Abn	_	
Genitalia	□ N □ Abn	_	Right from the Start (RFTS) 1-800-642-9704
Back	□ N □ Abn		☐ Birth to Three (BTT) 1-800-642-9704
Hips	□ N □ Abn		□ Children with Special HealthCare Needs (CSHCN)
Extremities	□ N □ Abn		1-800-642-9704
Jaundice 🛛 Yes 🗆] No		□ Women, Infants and Children (WIC) 1-304-558-0030
Possible Signs of	Abuse/Neglect 🛛 Yes 🖾 No		
-	lestions		
			Medical Necessity
			For treatment plans requiring authorization, please complet
· · · · · · · · · · · · · · · · · · ·			page 3. Contact a HealthCheck Regional Program Specialist for
<u></u>			assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Ago Appropriat	e Health Education/Anticipatory		_
	ult Bright Futures, Fourth Edition. For further		Follow Up/Next Visit □ 1 month of age □ 2 months of age
	brightfutures.aap.org)		
	s of Health, Parental/Family Health and		Other
	n Behavior and Care, Nutrition and Feeding,		
and Safety			
Discussed	□ Handouts Given		Operation has been realised and in complete
			□ Screen has been reviewed and is complete
<u></u>		_	
<u></u>			Please Print Name of Facility or Clinician
<u></u>			
			West Virginia
			Department of
			HEALT

Screen Date

Screen Date Early and Periodic	Screening, D		nia Department of Healt atment (EPSDT) HealthC		am Preventive Health Scree	By 1 Month Form
Name	DOB	B	Age	Sex: 🛛	M □ F Race/Ethnicity	
Weight Length Weight for Length	HC	Pulse	BP (optional)	Res	p Temp	Pulse Ox (optional)
Allergies D NKDA						
Current meds None						
Foster child	Kinship placen	nent		D Child	with special health care needs_	
Accompanied by Parent Grandparent Foster parent	∃ Foster organi	zation			D Other	
Medical History Initial screen Family health history reviewed In utero substance exposure Yes No Maternal Hep C exposure Yes No	 None I What kind Relation Child ca emotional support/he 	□ Slight □ Moderate of stress? (✓ Check Iships (partner, family Ire □ Drugs □ Alcol and/or sexual) □ Fai Ip □ Financial/mone	k those that apply) / and/or friends) □ School/ hol □ Violence/abuse (phy mily member incarcerated y □ Emotional loss □ He	rsical, □ Lack of alth	Subscale 2 (✓ Check one for Does your child cry a lot? □ Not at all (0) □ Somewhat Does your child have a hard tir □ Not at all (0) □ Somewhat Is your child fussy or irritable? □ Not at all (0) □ Somewhat	 (1) □ Very much (2) ne calming down? (1) □ Very much (2) (1) □ Very much (2)
Birth weightDischarge weight High birth score Yes No<	Maternal I *Positive Postnatal Feelings o Little intere Not at a Feeling do Feeling do	Depression/Patient I screen = numbered e, see Periodicity So Depression Scale (I over the past 2 week est or pleasure in doir II (0)	xs: (✓ Check one for each ong things s (1) □ More than ½ the c	Q-2) Irgh question) days (2)	Is it hard to comfort your child? □ Not at all (0) □ Somewhat Subscale 2 score Subscale 3 (✓ Check one for Is it hard to keep your child on □ Not at all (0) □ Somewhat Is it hard to put your child to ske □ Not at all (0) □ Somewhat Is it hard to get enough sleep to □ Not at all (0) □ Somewhat Does your child have trouble s □ Not at all (0) □ Somewhat Does your child have trouble s □ Not at all (0) □ Somewhat Subscale 3 score	 (1) □ Very much (2) each question) a schedule or routine? (1) □ Very much (2) eep? (1) □ Very much (2) pecause of your child? (1) □ Very much (2) taying asleep? (1) □ Very much (2)
Do you have concerns about meeting basic family needs daily and/o 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?	Baby Pedi *Positive : the 3 subs	scales. Further eval	responses 3 or greater in uation and/or investigatio		you with his/her eyes □ Child as bringing hands to mouth □ □ Child calms when picked up	■Ip □ Child looks at you and follows has self-comforting behaviors, such Child becomes fussy when bored
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, can seat, diapers, etc.)? □ Yes □ No	 Not at a Does your Not at a 	II (0) □ Somewhat (child have a hard tim II (0) □ Somewhat (child have a hard tim II (0) □ Somewhat (child mind being held	 1) □ Very much (2) ae with change? 1) □ Very much (2) d by other people? 1) □ Very much (2) 		short vowel sounds	lerts to unexpected sounds ☐ Child ☐ Child shows signs of sensitivity to , tremors, excessive startles) cries for hunger and tiredness both arms and legs together n on stomach fingers slightly when at rest
					Continue on nego 2	West Virginia

Continue on page 2



Name		DOB	Age Sex: 🗆 M 🗆 F
General Health		Signs of Abuse/Neglect	Plan of Care
Growth plotted or	n growth chart		Assessment
Do you think your ch			Well Child Other Diagnosis
Do you think your ch	nild hears okay? □ Yes □ No		
Oral Health		Age Appropriate Health Education/Anticipatory	Immunizations
Water source: D F	Public 🛛 Well 🛛 Tested	Guidance (Consult Bright Futures, Fourth Edition. For further	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Nutrition/Close		information: https://brightfutures.aap.org)	
Nutrition/Sleep	requency	Social Determinants of Health, Parental/Family Health and	Labs
□ Breastreeding - F	requency mount Frequency	Well-Being, Infant Behavior and Development, Nutrition and Feeding,	□ TB skin test <i>(if high risk)</i>
		and Salety	□ Hepatitis B Screen (HBsAG) (if high risk)
□ Normal eliminatio	n	Discussed Handouts Given	
	patterns		
	sleep	Questions/Concerns/Notes	
	Irs at a time		
□ Can stay awake f	or 1 hour or longer		Referrals Atternal depression - Help4WV.com/1-844-435-7498
			Developmental
*Tuberculosis Risk	k □ Low risk □ High risk		□ Other
*Hepatitis B Risk	🗆 Low risk 🛛 High risk		□ Right from the Start (RFTS) 1-800-642-9704
*Soo Poriodicity Se	chedule for Risk Factors		□ Right from the start (RF13) 1-000-042-9704 □ Birth to Three (BTT) 1-800-642-9704
See Ferrouncity St			□ Children with Special HealthCare Needs (CSHCN)
Dhusiaal Exami	notion (M-Manual Abar Abar and D		1-800-642-9704
	nation (N=Normal, Abn=Abnormal)		□ Women, Infants and Children (WIC) 1-304-558-0030
	e 🗆 N 🗆 Abn		,
Skin	□ N □ Abn		Medical Necessity
Neurological	□ N □ Abn		For treatment plans requiring authorization, please complete
Reflexes	□ N □ Abn		page 3. Contact a HealthCheck Regional Program Specialist for
Head	□ N □ Abn		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Fontanelles	□ N □ Abn		-
Neck	□ N □ Abn		
Eyes	□ N □ Abn		Follow Up/Next Visit D 2 months of age
Red Reflex	□ N □ Abn		□ Other
Ears	□ N □ Abn		
Nose	□ N □ Abn		
Oral Cavity/Throat	□ N □ Abn		Screen has been reviewed and is complete
Lung	□ N □ Abn		
Heart	□ N □ Abn		
Pulses	□ N □ Abn		Please Print Name of Facility or Clinician
Abdomen	□ N □ Abn		
Genitalia	□ N □ Abn		
Back	□ N □ Abn		
Hips	□ N □ Abn		Signature of Clinician/Title
Extremities	□ N □ Abn		West Virginia
			TEALIF

Screen Date Early and Periodi	West Virginia c Screening, Diagnosis, and Treatm	Department of Health ent (EPSDT) HealthCheck Prog	gram Preventive	Health Screen	2 Month Form
Name			-		city
Weight Length Weight for Length	HC Pulse	BP (optional) Re	esp 1	[emp	Pulse Ox (optional)
Allergies D NKDA					
Current meds None				<u></u>	
Foster child Kin:	ship placement	Child with	h special health car	e needs	
Accompanied by □ Parent □ Grandparent □ Foster parent	□ Foster organization		D Other		
Medical History Initial screen Periodic screen Family health history reviewed	How much stress are you and you □ None □ Slight □ Moderate □ What kind of stress ? (✓ <i>Check th</i> □ Relationships (partner, family ar	□ Sever ose that apply)	Does your child □ Not at all (0) Does your child	Somewhat (1) Somewhat (1)) □ Very much (2) calming down?
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		/ member incarcerated □ Lack of] Emotional loss □ Health	Is your child fus □ Not at all (0) Is it hard to com □ Not at all (0)	sy or irritable? □ Somewhat (1) nfort your child? □ Somewhat (1))
Recent injuries, surgeries, illnesses, visits to other providers and/o	*If positive, see Periodicity Sche Postnatal Depression Scale (EPI Feelings over the past 2 weeks:	ponses 3 or greater dule for link to Edinburgh DS) (< Check one for each question)	Is it hard to kee □ Not at all (0) Is it hard to put □ Not at all (0)	□ Somewhat (1) your child to sleer □ Somewhat (1)	schedule or routine?) □ Very much (2)
Psychosocial/Behavioral What is your family's living situation?	Little interest or pleasure in doing t Little interest or pleasure in doing t Not at all (0) Several days (7 Nearly every day (3) Feeling down, depressed, or hopel Not at all (0) Several days (7) □ More than ½ the days (2) ess	 □ Not at all (0) Does your child □ Not at all (0) 	□ Somewhat (1) have trouble stay) □ Very much (2) ring asleep?) □ Very much (2)
Do you have the things you need to take care of your baby (crib, c seat, diapers, etc.)? □ Yes □ No	ar □ Not at all (0) □ Several days (´ □ Nearly every day (3)) \square more than $\frac{1}{2}$ the days (2)			
Do you have concerns about meeting basic family needs daily and monthly (food, housing, heat, etc.)?	Baby Pediatric Symptom Check		Social Langua	I Surveillance (✓ ge and Self–help sounds that let yc	Check those that apply) Child smiles responsively know if he/she is happy Child smiles appy
Who do you contact for help and/or support?	*Positive screen = numbered res the 3 subscales. Further evaluat		cooing sounds	ge (Expressive an	nd Receptive)
Are you and/or your partner working outside home? Yes No Child care plans? Child exposed to Cigarettes E-Cigarettes/Vaping Alcot Drugs (prescription or otherwise)	Subscale 1 (✓ Check one for each nol Does your child have a hard time b □ Not at all (0) □ Somewhat (1) Does your child have a hard time in	eing with people? □ Very much (2) n new places?	keeps head stea	ady when held in a Child can open ar	and chest when on stomach ☐ Child sitting position nd shut hands ☐ Child can briefly
	 □ Not at all (0) □ Somewhat (1) Does your child have a hard time v □ Not at all (0) □ Somewhat (1) Does your child mind being held by □ Not at all (0) □ Somewhat (1) Subscale 1 score 	/ith change? □ Very much (2) / other people? □ Very much (2)	Continue on	page 2	West Virginia Department of

Name	DOB	Age Sex: 🗆 M 🛛 F
General Health	Age Appropriate Health Education/Anticipatory	Plan of Care
Growth plotted on growth chart	Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment
Do you think your child sees okay? □ Yes □ No	information: https://brightfutures.aap.org)	Well Child Other Diagnosis
Do you think your child hears okay? □ Yes □ No	Social Determinants of Health, Parental/Family Health and	Immunizations
- ···· ···	Well-Being, Infant Behavior and Development, Nutrition and	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Oral Health	Feeding, and Safety	
Water source: Public Well Tested	□ Discussed □ Handouts Given	Labs
Nu świśli z w /Ola z w	Questions/Concerns/Notes	□ Hepatitis B Screen (HBsAG) (<i>if high risk</i>)
Nutrition/Sleep Breastfeeding - Frequency	Questions/concerns/notes	□ Other
Bottle feeding - Amount Frequency		_
Formula Frequency		—
□ Normal elimination		—
□ Normal sleeping patterns		
□ Place on back to sleep		Referrals □ Maternal depression - Help4WV.com/1-844-435-7498
□ Sleeps 3 to 4 hours at a time		─ □ Developmental
Concerns and/or questions		— 🗆 Other
		☐ Right from the Start (RFTS) 1-800-642-9704
Hepatitis B Risk (See Periodicity Schedule for Risk Fac	tors)	 □ Birth to Three (BTT) 1-800-642-9704 □ Children with Special HealthCare Needs (CSHCN)
🗆 Low risk 🛛 High risk		- 1-800-642-9704
		─ □ Women, Infants and Children (WIC) 1-304-558-0030
Physical Examination (N=Normal, Abn=Abnormal,)	
General Appearance 🛛 N 🗆 Abn		_
Skin		Medical Necessity
Neurological 🛛 N 🗆 Abn		For treatment plans requiring authorization, please complete
Reflexes		page 3. Contact a HealthCheck Regional Program Specialist for
Head		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Fontanelles		_
Neck		— — — — — — — — — — — — — — — — — — —
Eyes 🛛 N 🗆 Abn		Follow Up/Next Visit
Red Reflex		□ Other
Ocular Alignment		_
Ears 🛛 N 🗆 Abn		—
Nose 🛛 N 🗆 Abn		
Oral Cavity/Throat 🛛 N 🗆 Abn		
Lung DNDAbn		—
Heart 🛛 N 🗆 Abn		—
Pulses		
Abdomen		Please Print Name of Facility or Clinician
Genitalia 🛛 N 🗆 Abn		
Back		
Hips 🛛 N 🗆 Abn		_
Extremities		West Virginia
Signs of Abuse/Neglect		HEALTH

Screen Date Early and Periodic S	West Vir Screening, Diagnosis, and T	4 Month Form			
Name	DOB	Age	Sex: □ M	□ F Race/Et	hnicity
Weight Length Weight for Length	HC Pulse	BP (optional)	_ Resp	Temp	Pulse Ox (<i>optional</i>)
Allergies D NKDA					
Current meds None					
Foster child Ki	nship placement	□(Child with special hea	alth care needs	
Accompanied by □ Parent □ Grandparent □ Foster parent □	Foster organization		D Othe	۶r	
Medical History Initial screen Family health history reviewed	How much stress are you ar None Slight Moder What kind of stress? (✓ Ch Relationships (partner, fan	rate	Does your ch □ Not at all (0	0) D Somewhat	r <i>each question)</i> t (1) □ Very much (2) ime calming down?
In utero substance exposure □ Yes □ No Maternal Hep C exposure □ Yes □ No High birth score □ Yes □ No	emotional and/or sexual)	cohol □ Violence/abuse (physical, Family member incarcerated □ Lac oney □ Emotional loss □ Health	k of Is your child f □ Not at all (0 Is it hard to co □ Not at all (0	ussy or irritable? 0) □ Somewhat omfort your child 0) □ Somewhat	t (1) □ Very much (2) ? t (1) □ Very much (2)
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	*Positive screen = number		Subscale 3 (Is it hard to ke	✓ Check one for eep your child on	r <i>each question)</i> n a schedule or routine? t (1) □ Very much (2)
Psychosocial/Behavioral What is your family's living situation?	Postnatal Depression Scale Feelings over the past 2 we Little interest or pleasure in d	eeks: (√ Check one for each questio loing things	Is it hard to po (n) □ Not at all (0 Is it hard to ge	ut your child to sl 0) □ Somewhat et enough sleep	leep? t (1) □ Very much (2) because of your child?
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No	□ Nearly every day (3) Feeling down, depressed, or □ Not at all (0) □ Several d	lays (1) □ More than ½ the days (2 hopeless lays (1) □ More than ½ the days (2	Does your ch □ Not at all (0	ild have trouble s 0) □ Somewhat	t (1) □ Very much (2) staying asleep? t (1) □ Very much (2)
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?	n □ Nearly every day (3)		-		
Who do you contact for help and/or support?	Baby Pediatric Symptom C	hecklist (RPSC)	Social Langu	tal Surveillance uage and Self–h	e (<i>✓ Check those that apply)</i> eelp □ Child can laugh out loud
Are you and/or your partner working outside home? Yes No Child care	*Positive screen = number	ed responses 3 or greater in <u>any</u> o valuation and/or investigation may	of Verbal Langu	uage (Expressive	nother caregiver when upset e and Receptive)
Child has ability to separate from parents/caregivers □ Yes □ No	be needed.	5 ,			ended cooing sounds pport himself/herself on elbows and
Child exposed to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise)	Subscale 1 (✓ Check one fo Does your child have a hard □ Not at all (0) □ Somewha Does your child have a hard □ Not at all (0) □ Somewha	time being with people? at (1) □ Very much (2) time in new places?	Fine Motor	□ Child can keep	child can roll over from stomach to back o his/her hands unfisted □ Child can Child can grasp objects
	Does your child have a hard □ Not at all (0) □ Somewha Does your child mind being h □ Not at all (0) □ Somewha	at (1)			
	Subscale 1 score	() , ()	Continue o	on page 2	West Virginia Department of HEALTH

Name		DOB	Age Sex: 🗆 M 🛛 F
General Health		Signs of Abuse/Neglect	Plan of Care
Growth plotted on	growth chart		Assessment
Do you think your ch	ild sees okay? □ Yes □ No	Age Appropriate Health Education/Anticipatory	Well Child Other Diagnosis
Do you think your ch	ild hears okay? □ Yes □ No	Guidance (Consult Bright Futures, Fourth Edition. For further	
Oral Health		information: https://brightfutures.aap.org) Social Determinants of Health, Infant Behavior and Development,	Immunizations
Water source: DP	ublic DWell DTested	Oral Health, Nutrition and Feeding, and Safety	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Nutrition/Sleep	equency	Discussed Handouts Given	Labs □ Hemoglobin/hematocrit <i>(if high risk)</i>
Bottle feeding - Ar	nount Frequency	- Ouestiene/Concerne/Netes	□ Henoglobil/Inematocit (<i>ii high risk</i>) □ Hepatitis B Screen (HBsAG) <i>(if high risk)</i>
□ Formula		Questions/Concerns/Notes	Other
□ Juice □ Water		•	_
	oods D Normal eating habits		_
□ Vitamins	<u>-</u>		_
□ Normal elimination	1		_
	atterns		Referrals D Maternal depression - Help4WV.com/1-844-435-7498
	sleep		□ Developmental
			□ Other
*Anemia Risk (Hem	oglobin/Hematocrit)		_
*Hepatitis B Risk	Low risk High risk	ζ	□ Right from the Start (RFTS) 1-800-642-9704
*See Periodicity Sc	hedule for Risk Factors		Birth to Three (BTT) 1-800-642-9704
			□ Children with Special HealthCare Needs (CSHCN)
Physical Examin	nation (N=Normal, Abn=Abnormal)		1-800-642-9704
•	e □ N □ Abn		□ Women, Infants and Children (WIC) 1-304-558-0030
Skin		-	_
		-	
Neurological		-	— Medical Necessity
Reflexes		-	- For treatment plans requiring authorization, please complete
Head		-	 page 3. Contact a HealthCheck Regional Program Specialist for
Fontanelles	□ N □ Abn	-	 assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Neck	□ N □ Abn	-	-
Eyes Ded Deflex		_	─ Follow Up/Next Visit □ 6 months of age
Red Reflex			□ Other
Ocular Alignment	□ N □ Abn	-	_
Ears	□ N □ Abn	-	
Nose	□ N □ Abn	_	□ Screen has been reviewed and is complete
Oral Cavity/Throat	□ N □ Abn	-	_
Lung	□ N □ Abn	_	_
Heart	□ N □ Abn		Please Print Name of Facility or Clinician
Pulses	□ N □ Abn	-	_
Abdomen		-	_
Genitalia	□ N □ Abn	-	
Back	□ N □ Abn	-	 Signature of Clinician/Title
Hips	□ N □ Abn	-	- West Virginia
Extremities	□ N □ Abn	-	— Department of

WVDH/BPH/OMCFH/HC 05.01.2024

Screen Date Early and Periodic S	West Virginia creening, Diagnosis, and Treatmo	Department of Health ent (EPSDT) HealthCheck Pı	ogram Prevent	ive Health Scree	6 Month Form
Name		. ,	-		
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp	Temp	Pulse Ox (optional)
Allergies D NKDA					
Current meds Done					
Foster child Kinst	nip placement	Child	d with special hea	alth care needs	
Accompanied by Parent Grandparent Foster parent I	Foster organization		🗆 Ot	her	
Medical History Initial screen Periodic screen Family health history reviewed	How much stress are you and your None Slight Moderate What kind of stress? (✓ Check the Relationships (partner, family and	Severe () () () () () () () () () () () () ()	Does your o □ Not at all	· · /	each question) (1) □ Very much (2) ne calming down?
In utero substance exposure □ Yes □ No Maternal Hep C exposure □ Yes □ No High birth score □ Yes □ No	□ Child care □ Drugs □ Alcohol emotional and/or sexual) □ Family support/help □ Financial/money □ insurance □ Other	member incarcerated □ Lack] Emotional loss □ Health	of Is your child D Not at all Is it hard to	d fussy or irritable? (0) □ Somewhat comfort your child?	(1) □ Very much (2)
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Maternal Depression/Patient Hea *Positive screen = numbered res *If positive, see Periodicity Scheo Postnatal Depression Scale (EPD	ponses 3 or greater dule for link to Edinburgh	Subscale 3 Is it hard to	I (✓ <i>Check one for</i> keep your child on	each question) a schedule or routine? (1) □ Very much (2)
Psychosocial/Behavioral What is your family's living situation?	Feelings over the past 2 weeks: (Little interest or pleasure in doing th □ Not at all (0) □ Several days (1)	✓ Check one for each question) iings	Is it hard to □ Not at all Is it hard to	put your child to sl (0) □ Somewhat get enough sleep b	eep? (1) □ Very much (2) because of your child?
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	 □ Nearly every day (3) Feeling down, depressed, or hopele □ Not at all (0) □ Several days (1) □ Nearly every day (3) 		Does your o □ Not at all	child have trouble s	(1) □ Very much (2)
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No				ental Surveillance	(✓ Check those that apply)
Who do you contact for help and/or support?	Baby Pediatric Symptom Checkli	st (BPSC)			elp □ Child can pat or smile at his/her hen you call his/her name
Are you and/or your partner working outside home? Yes No Child care	*Positive screen = numbered res the 3 subscales. Further evaluation be needed.		□ Child car	n make sounds like	e and Receptive) □ Child can babble "ga," "ma," or "ba" over from back to stomach □ Child
Child has ability to separate from parents/caregivers \Box Yes \Box No	Subscale 1 (\checkmark Check one for each		can sit brief	ly without support	
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?	Does your child have a hard time be Not at all (0) Somewhat (1) Does your child have a hard time in Not at all (0) Somewhat (1) Does your child have a hard time w	□ Very much (2) new places? □ Very much (2)		n rake small objects	a toy from one hand to another with 4 fingers
	 □ Not at all (0) □ Somewhat (1) □ Does your child mind being held by □ Not at all (0) □ Somewhat (1) Subscale 1 score 	□ Very much (2) other people?	– Continue	e on page 2	West Virginia Department of HEALTH

Name		DOB	Age Sex: 🗆 M 🛛 F
General Health	Lung	□ N □ Abn	Plan of Care
□ Growth plotted on growth chart	Heart	□ N □ Abn	Assessment
Do you think your child sees okay? □ Yes □ No	Pulses	□ N □ Abn	UWell Child Other Diagnosis
Do you think your child hears okay? □ Yes □ No	Abdomen	□ N □ Abn	
	Genitalia	□ N □ Abn	Immunizations
Oral Health	Back	□ N □ Abn	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Tooth eruption □ Yes □ No	Hips	□ N □ Abn	
Current oral health problems	Extremities	□ N □ Abn	Labs
Water source Public Well Tested			□ Blood lead (<i>if high risk</i>) (<i>enter into WVSIIS</i>) □ TB skin test (<i>if high risk</i>)
Fluoride supplementation	Signs of Abuse/Neg	llect □ Yes □ No	□ Hepatitis B Screen (HBsAG) (if high risk)
Fluoride varnish applied (apply every 3 to 6 months)			$-\Box$ Other
□ Yes □ No			-
Nutrition/Sleep Breastfeeding - Frequency			
Bottle feeding - Amount Frequency		Health Education/Anticipatory	Referrals
□ Formula		t Bright Futures, Fourth Edition. For further	□ Developmental
□ Juice □ Water	Information: https://bi		Other
□ Has started solid foods □ Normal eating habits		of Health, Infant Behavior and Development,	
		and Feeding, and Safety	□ Right from the Start (RFTS) 1-800-642-9704
□ Normal elimination	Discussed	□ Handouts Given	Birth to Three (BTT) 1-800-642-9704
□ Normal sleeping patterns			Children with Special HealthCare Needs (CSHCN)
□ Place on back to sleep	Questions/Conc	erns/Notes	1-800-642-9704
			□ Women, Infants and Children (WIC) 1-304-558-0030
*Lead Risk			_
*Tuberculosis Risk			— Medical Necessity
* Hepatitis B Risk			- For treatment plans requiring authorization, please complete
*See Periodicity Schedule for Risk Factors			 page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
			- assistance at 1-800-642-9704 or dnnr.wv.gov/neathcheck.
Physical Examination (N=Normal, Abn=Abnormal)			─ Follow Up/Next Visit □ 9 months of age
General Appearance 🛛 N 🗆 Abn			
Skin 🛛 N 🗆 Abn			Other
Neurological 🛛 N 🗆 Abn			_
Reflexes			□ Screen has been reviewed and is complete
Head 🛛 N 🗆 Abn			- ·
Fontanelles			—
Neck 🛛 N 🗆 Abn			
Eyes 🛛 N 🗆 Abn			 Please Print Name of Facility or Clinician
Red Reflex			—
Ocular Alignment			—
Ears 🛛 N 🗆 Abn			 Signature of Clinician/Title
Nose 🛛 N 🗆 Abn			– Signature of Childrani, The – R West Virginia
Oral Cavity/Throat 🛛 N 🗖 Abn			Department of
			"HÉALTH

Screen Date Early and Periodic So	West creening, Diagnosis, an	Virginia Department of Health d Treatment (EPSDT) HealthChe	eck Program Prever	ntive Health Screen	9 Month Form
Weight Length Weight for Length	_ HC Pulse_	BP (optional)	Resp	Temp	Pulse Ox (optional)
Allergies D NKDA					
Current meds D None					
Foster child Kinship	placement		Child with special hea	Ith care needs	
Accompanied by Parent Grandparent Foster parent F	oster organization		□ 0	Other	
Medical History Initial screen Family health history reviewed Parental history of postpartum depression In utero substance exposure Yes No Maternal Hep C exposure	□ None □ Slight □ Mo What kind of stress? (✓ □ Relationships (partner, □ Child care □ Drugs □ emotional and/or sexual) support/help □ Financia insurance □ Other		Is it hard to □ Not at a ork Is it hard to cal, □ Not at a I Lack of Is it hard to th □ Not at a Does your	all (0) □ Somewhat (o put your child to sle all (0) □ Somewhat (o get enough sleep be all (0) □ Somewhat (o child have trouble sta	a schedule or routine? 1) □ Very much (2) ep? 1) □ Very much (2) ecause of your child? 1) □ Very much (2)
High birth score	the 3 subscales. Furthe	m Checklist (BPSC) bered responses 3 or greater in <u>a</u> r evaluation and/or investigation	Subscale Develop Develop Develop may Standardi	3 score omental pmental surveillanc ized Screening Tool	e and screening completed with
Psychosocial/Behavioral What is your family's living situation?	□ Not at all (0) □ Some Does your child have a h	ard time being with people? what (1) □ Very much (2) ard time in new places?	Results in	child's record	
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	Does your child have a h Does your child mind bein Not at all (0) Some Not at all (0) Some	ewhat (1) D Very much (2)	Do you thi	plotted on growth chank your child sees ok	ay? □Yes □No
Who do you contact for help and/or support?	Subscale 2 (✓ Check on Does your child cry a lot?	e for each question)	Oral Heal		(ay? □ Yes □ No
Are you and/or your partner working outside home? □ Yes □ No Child care	, ,	ewhat (1) D Very much (2)	Current or	ption □ Yes □ No al health problems urce □ Public □ Wel	
Child has ability to separate from parents/caregivers □ Yes □ No	□ Not at all (0) □ Some Is your child fussy or irrita	what (1) D Very much (2) able?	Fluoride s Fluoride v	upplementation □ Ye arnish applied <i>(apply</i>	every 3 to 6 months)
Child exposed to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise)	Is it hard to comfort your	ewhat (1) D Very much (2)		No e on page 2	
					West Virginia Department of HEALTH

Screen	Date
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Name	DOB	Age Sex: D M D F
Nutrition/Sleep Breastfeeding - Frequency Bottle feeding - Amount Formula Juice Water Has started solid foods Table foods Normal eating habits Vitamins	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	Plan of Care Assessment Well Child Other Diagnosis Immunizations UTD Given, see immunization record Entered into WVSIIS
Normal elimination Normal sleeping patterns Place on back to sleep	Questions/Concerns/Notes	Labs □ Blood lead (if high risk) (enter into WVSIIS) □ Hepatitis B Screen (HBsAG) (if high risk) □ Other
*Lead Risk		Referrals □ Developmental □ Other
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		 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
Eyes I Abn Red Reflex I Abn Ocular Alignment I Abn Ears I Abn Nose I Abn		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.
Oral Cavity/Throat I Abn Lung I Abn Heart I Abn Pulses I Abn	-	Follow Up/Next Visit □ 12 months of age □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □
Abdomen Image: N Image: Abn Image: Abn </td <td></td> <td>☐ Screen has been reviewed and is complete</td>		☐ Screen has been reviewed and is complete
Hips □ N □ Abn Extremities □ N □ Abn Signs of Abuse/Neglect □ Yes □ No		Please Print Name of Facility or Clinician
		Signature of Clinician/Title

9 Month Form, Page 2

Screen Date Early and Periodic \$	West Virginia Screening, Diagnosis, and Treatm	Department of Health ent (EPSDT) HealthCheck P	rogram Preventive	Health Screer	12 Month Form
Name					
Weight Length Weight for Length	HC Pulse	BP (<i>optional</i>)	Resp	Temp	Pulse Ox (optional)
Allergies D NKDA					
Current meds Done					
Foster child Kins	hip placement	□ Chi	ld with special health	care needs	
Accompanied by Parent Grandparent Foster parent	Foster organization		D Other	<u> </u>	
Medical History Initial screen Family health history reviewed Parental history of postpartum depression Yes	How much stress are you and you □ None □ Slight □ Moderate What kind of stress ? (✓ <i>Check th</i> □ Relationships (partner, family ar □ Child care □ Drugs □ Alcohol	□ Severe lose that apply) nd/or friends) □ School/work □ Violence/abuse (physical,	Is it hard to kee □ Not at all (0) Is it hard to put □ Not at all (0)) □ Somewhat (t your child to slee) □ Somewhat (a schedule or routine? 1) □ Very much (2) ep? 1) □ Very much (2)
In utero substance exposure □ Yes □ No Maternal Hep C exposure □ Yes □ No High birth score □ Yes □ No	emotional and/or sexual)	∃ Emotional loss □ Health	Does your child) □ Somewhat(d have trouble sta) □ Somewhat(ecause of your child? 1) □ Very much (2) aying asleep? 1) □ Very much (2)
Child recent injuries, surgeries, illnesses, visits to other providers and or hospitalizations:	*Positive screen = numbered res the 3 subscales. Further evaluat be needed.	sponses 3 or greater in <u>anv</u> of ion and/or investigation may	Social Langua (point to reque	al Surveillance (age and Self–he	✓ Check those that apply) Ip □ *Child can protoimperative point Child can imitate new gestures
Psychosocial/Behavioral What is your family's living situation?	Subscale 1 (✓ Check one for each Does your child have a hard time b □ Not at all (0) □ Somewhat (1) Does your child have a hard time in □ Not at all (0) □ Somewhat (1)	veing with people? □ Very much (2) n new places? □ Very much (2)	Verbal Langua □ *Child can ir "Dada" or "Mar "Mama," "Dada	age (Expressive a mitate vocalization ma" specifically [a," or personal na	and Receptive) □ *Child can babble ns and sounds □ Child can use □ Child can use 1 word other than me
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	Does your child have a hard time v □ Not at all (0) □ Somewhat (1) Does your child mind being held by □ Not at all (0) □ Somewhat (1) Subscale 1 acces	□ Very much (2) y other people? □ Very much (2)	stand without s Fine Motor □	support I Child can drop a	first independent steps □ Child can an object in a cup □ Child can pick up er grasp □ Child can pick up food and
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?	Subscale 1 score Subscale 2 (✓ Check one for each			hese milestone:	s = Autism Screen
Who do you contact for help and/or support?	Does your child cry a lot? □ Not at all (0) □ Somewhat (1)		Concerns and/	or questions	
Are you and/or your partner working outside home? □ Yes □ No Child care	Does your child have a hard time o □ Not at all (0) □ Somewhat (1) Is your child fussy or irritable?	5	General He	alth	
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	□ Not at all (0) □ Somewhat (1) Is it hard to comfort your child? □ Not at all (0) □ Somewhat (1) Subscale 2 score	□ Very much (2)	Do you think y	ted on growth cha our child sees oka our child hears of	ay? □Yes □No
Concerns and/or questions	-		Continue or	n page 2	West Virginia Department of HEALTH



Name		DOB	Age Sex: 🗆 M 🛛 F
Oral Health	Pulses	□ N □ Abn	Plan of Care
Dental referral required at 12 months	Abdomen	□ N □ Abn	Assessment
Tooth eruption D Yes D No	Genitalia	□ N □ Abn	□ Well Child □ Other Diagnosis
Current oral health problems	Back	□ N □ Abn	
Water source Public Well Tested	Hips	□ N □ Abn	Immunizations
Fluoride supplementation	Extremities	□ N □ Abn	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Fluoride varnish applied (apply every 3 to 6 months)			
□ Yes □ No	— Signs of Abuse/	/Neglect □ Yes □ No	Labs
Nutrition/Sleep			Hemoglobin/hematocrit (required at 12 months)
Breastfeeding - Frequency			□ Blood lead (required at 12 months) (enter into WVSIIS)
Bottle feeding - Amount Frequency	Age Appropr	iate Health Education/Anticipatory	□ TB skin test (<i>if high risk</i>)
□ Formula	5 PP P	nsult Bright Futures, Fourth Edition. For furthe	□ Hepatitis B Screen (HBsAG) <i>(if high risk)</i> Pr □ Other
Plans for weaning	Culturios (60	s://brightfutures.aap.org)	
□ Milk □ Juice □ Water		ants of Health, Establishing Routines, Feeding	and
□ Has started solid foods □ Table foods □ Normal eating ha		s, Establishing a Dental Home, and Safety	
□ Vitamins	Discussed	□ Handouts Given	Referrals
□ Normal elimination			□ Developmental □ Dental □ Blood lead ≥5ug/dl
Normal sleeping patterns	— Questions/Co	oncerns/Notes	□ Other
*Anomia Diak (Ilamaslahin/Ilamataarit)			
*Anemia Risk (Hemoglobin/Hematocrit) Hemoglobin/hematocrit required at 12 months			
nomogiosin nomatoone roquiroù at r2 montro			Birth to Three (BTT) 1-800-642-9704
*Lead Risk			Children with Special HealthCare Needs (CSHCN)
Blood lead required at 12 months			1-800-642-9704
*Tuberculosis Risk			□ Women, Infants and Children (WIC) 1-304-558-0030
*Hepatitis B Risk			
*Cas Daviadiaity Cabadula far Diak Fastara			Medical Necessity
*See Periodicity Schedule for Risk Factors		*****	For treatment plans requiring authorization, please complete
Physical Examination (N-Normal Abra Abraryo)		***************************************	page 3. Contact a HealthCheck Regional Program Specialist for
Physical Examination (N=Normal, Abn=Abnormal)			assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
General Appearance D N D Abn			
Skin			Follow Up/Next Visit □ 15 months of age
Neurological			
Reflexes			□ Other
Head			
Fontanelles			───
Neck			
Eyes			
Red Reflex			
Ocular Alignment			Please Print Name of Facility or Clinician
Ears			
Nose			
Oral Cavity/Throat			
Lung 🛛 N 🗆 Abn			Signature of Clinician/Title
Heart 🛛 N 🗆 Abn			Department of
			*HEALTH

Screen Date

12 Month Form, Page 2

Screen Date Early and Periodic S	West Virginia creening, Diagnosis, and Treatr	a Department of Heal nent (EPSDT) Health		am Preventive Health Scre	15 Month Form
	_ DOB				
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp	Temp	Pulse Ox (<i>optional</i>)
Allergies D NKDA					
Current meds					
Foster child	Kinship placement		Child wi	th special health care needs_	
Accompanied by □ Parent □ Grandparent □ Foster parent □	Foster organization			D Other	
Medical History Initial screen Periodic screen Family health history reviewed Parental history of postpartum depression Yes In utero substance exposure Yes	How much stress are you and yo None Slight Moderate What kind of stress ? (< Check t Relationships (partner, family a Child care Drugs Alcoho emotional and/or sexual) Famil support/help Financial/money insurance Other	□ Severe hose that apply) ind/or friends) □ Schoo I □ Violence/abuse (ph ly member incarcerated □ Emotional loss □ He	ysical, □ Lack of	Subscale 3 (✓ Check one for Is it hard to keep your child or □ Not at all (0) □ Somewha Is it hard to put your child to s □ Not at all (0) □ Somewha Is it hard to get enough sleep □ Not at all (0) □ Somewha Does your child have troubles	n a schedule or routine? t (1) □ Very much (2) leep? t (1) □ Very much (2) because of your child? t (1) □ Very much (2) staying asleep?
Maternal Hep C exposure	Baby Pediatric Symptom Check *Positive screen = numbered re the 3 subscales. Further evalua be needed.	sponses 3 or greater i		(point to comment on an inter	e (✓ <i>Check those that apply)</i> help □ *Child can prodeclarative point resting object/event-will look alternatively
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	Subscale 1 (✓ Check one for eac Does your child have a hard time Not at all (0) □ Somewhat (1) Does your child have a hard time Not at all (0) □ Somewhat (1) Does your child have a hard time Not at all (0) □ Somewhat (1)	being with people? Very much (2) in new places? Very much (2) with change? Very much (2)		something to get help Child like "Where's your ball?" or "W imitate scribbling Child car Verbal Language (Expressiv words other than names C	rent) ☐ Child can point to ask for d can look around when you say things Vhere's your blanket?" ☐ Child can n drink from a cup with little spilling e and Receptive) ☐ Child can use 3 Child can speak in sounds like an can follow directions that do not include a
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No	Does your child mind being held b Not at all (0) Somewhat (1) Subscale 1 score	□ Very much (2)		Gross Motor □ Child can sq up a few steps □ Child can r	uat to pick up objects □ Child can crawl un ke marks with a crayon □ Child can drop
Who do you contact for help and/or support?	Subscale 2 (✓ Check one for eac	ch question)		an object in and take object o	,
Are you and/or your partner working outside home? Yes No Child care Child exposed to Cigarettes E-Cigarettes/Vaping Alcohol	Does your child cry a lot? Not at all (0) Somewhat (1) Does your child have a hard time Not at all (0) Somewhat (1) 	calming down?		*Absence of these mileston Concerns and/or questions	nes = Autism Screen
□ Drugs (prescription or otherwise) □ Access to firearm(s)/weapon(s) Are the firearm(s)/weapon(s) secured? □ Yes □ No □ NA	Is your child fussy or irritable?			General Health Growth plotted on growth c Do you think your child sees c Do you think your child hears Continue on page 2	okay? □Yes □No

Name			DOB	Age Sex: □ M □ F
Oral Health		Hips D	I □ Abn	Plan of Care
	isit		Ⅰ □ Abn	Assessment
Current oral health p				UWell Child Other Diagnosis
	ublic UWell UTested	Signs of Abuse/Neglect	□ Yes □ No	
	tation 🗆 Yes 🗆 No			Immunizations
	blied (apply every 3 to 6 months)			UTD Given, see immunization record Entered into WVSIIS
Nutrition/Cloop		Age Appropriate Hea	Ith Education/Anticipatory	Labs
Nutrition/Sleep	requerer	Guidance (Consult Brigh	nt Futures, Fourth Edition. For further	□ Hemoglobin/hematocrit (<i>if high risk</i>) □ Blood lead (<i>if high risk</i>) (enter into WVSIIS)
	requency Frequency	information: https://brightfu		□ Hepatitis B Screen (HBsAG) (<i>if high risk</i>)
Formula			Development, Sleep Routines and	□ Other
Plans for weaning			elopment, Behavior, and Discipline,	
□ Milk □ Juice □		Healthy Teeth, and Safety		
Normal eating hall		Discussed Discussed	indouts Given	Referrals
□ Vitamins		Questions/Concerns	Notos	Developmental Dental
Normal eliminatio	n	Questions/concerns	Notes	□ Other
Normal sleeping p	patterns			-
*Anomia Pick (Hor	noglobin/Hematocrit)		******	□ Birth to Three (BTT) 1-800-642-9704
	-			 Children with Special HealthCare Needs (CSHCN) 1.800.642.0704
*Lead Risk	Low risk High risk			 □ 1-000-042-3704 □ Women, Infants and Children (WIC) 1-304-558-0030
*Hepatitis B Risk	🗆 Low risk 🗖 High risk			_
*See Periodicity So	chedule for Risk Factors			Medical Necessity
	<i>a</i>			For treatment plans requiring authorization, please complete
-	nation (N=Normal, Abn=Abnormal)			page 3. Contact a HealthCheck Regional Program Specialist for
General Appearance	e 🗆 N 🗆 Abn			assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Skin	□ N □ Abn			
Neurological	□ N □ Abn			_
Reflexes	□ N □ Abn			Follow Up/Next Visit D 18 months of age
Head	□ N □ Abn			□ Other
Neck	□ N □ Abn			_
Eyes Red Reflex	□ N □ Abn			
	□ N □ Abn			Screen has been reviewed and is complete
Ocular Alignment Ears	□ N □ Abn			—
Nose	□ N □ Abn □ N □ Abn		******	—
Oral Cavity/Throat	□ N □ Abn			—
Lung	□ N □ Abn			Please Print Name of Facility or Clinician
Heart	□ N □ Abn			_
Pulses	□ N □ Abn		······	_
Abdomen	□ N □ Abn			
Genitalia	□ N □ Abn			_ Signature of Clinician/Title
Back	□ N □ Abn			West Virginia
				Department of HEALTH

WVDH/BPH/OMCFH/HC 05.01.2024

Screen Date	Early and Periodi	c Screening, D		rginia Department of H reatment (EPSDT) Hea		ram Preventive Health Scr	18 Month Form een
Name		DOB		Age	Sex: □ M	1 □ F Race/Ethnicity	
Weight Length	Weight for Length	HC	Pulse	BP (optional)) Re	sp Temp	Pulse Ox (optional)
Allergies D NKDA							
Current meds None							
Foster child	ОК	inship placemen	t		Child	with special health care needs	S
Accompanied by □ Parent □ Gra	andparent D Foster parent	□ Foster organi	zation			D Other	
Medical History Initial screen I Periodic scr Family health history reviewed Parental history of postpartum depresented		□ None [What kind □ Relation	☐ Slight ☐ Mode of stress? (✓ Ch ships (partner, far	nd your family under <u>now</u> rate □ Severe <i>eck those that apply)</i> nily and/or friends) □ So cohol □ Violence/abuse	chool/work	Autism screening comp M-CHAT-R/F Other to Results in child's record General Health	
In utero substance exposure	s □ No	emotional support/he insurance	and/or sexual) □ Ip □ Financial/mo	Family member incarcer	ated □ Lack of □ Health	□ Growth plotted on growth Do you think your child sees Do you think your child hear	s okay? □ Yes □ No
Child recent injuries, surgeries, illne or hospitalizations:		— Does your — □ Not at a	child seem nervou Ⅱ □ Somewhat □	⊐ Very much		Oral Health Date of last dental visit Current oral health problems Water source	Well Tested
Psychosocial/Behavioral What is your family's living situation	?	☐ Not at a Does your ☐ Not at a — Does your	II □ Somewhat I child have a hard	□ Very much en things are not done a □ Very much time with change?	a certain way?	Nutrition/Sleep	ply every 3 to 6 months)
Family relationships □ Good □ Ok Do you have the things you need to seat, diapers, etc.)? □ Yes □ No _	take care of your baby (crib, c	ar Does your □ Not at a ── Does your		on purpose? ⊐ Very much time calming down?		□ Formula Plans for weaning	Frequency
Do you have concerns about meetir monthly (food, housing, heat, etc.)?		l/or Is your chil ── □ Not at a	 □ 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? 			□ Milk □ Juice □ Water □ Normal eating habits □ Vitamins	
Who do you contact for help and/or	support?		II □ Somewhat I			 Normal elimination Normal sleeping patterns 	· · · · · · · · · · · · · · · · · · ·
Are you and/or your partner working Child care	outside home? □ Yes □ No					Hours of sleep each night?_ -	
Child exposed to Cigarettes C Drugs (prescription or otherwise) Access to firearm(s)/weapon(s) Are the firearm(s)/weapon(s) secure Witnessed violence/abuse C Scary experience that your child of	d? □ Yes □ No □ NA I Threatened with violence/abo	Develop	omental surveilla zed Screening To □ Other tool	nce and screening com pol Yes □ No	npleted with	Continue on page 2	West Virginia



ame		DOB	Age Sex: 🗆 M 🗖 I
'Anemia Risk (Hemo	globin/Hematocrit) Low risk	High risk Age Appropriate Health Education/Anticipatory	Plan of Care
Lead Risk	□ Low risk	□ High risk Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment
Hepatitis B Risk	□ Low risk	□ High risk <i>information: https://brightfutures.aap.org</i>) Temperament, Development, Toilet Training, Behavior and	Well Child Other Diagnosis
See Periodicity Sch	edule for Risk Factors	Discipline, Communication and Social Development, Television Viewing and Digital Media, Healthy Nutrition, and Safety Discussed Handouts Given	Immunizations
Physical Examin	ation (N=Normal, Abn=Abnorma	l)	Labs
•	□ N □ Abn	Questions/Concerns/Notes	□ Hemoglobin/hematocrit (<i>if high risk</i>)
Skin			□ Blood lead (if high risk) (enter into WVSIIS)
	□ N □ Abn □ N □ Abn		□ Hepatitis B Screen (HBsAG) <i>(if high risk)</i>
Neurological			Other
Reflexes	□ N □ Abn		
Head	□ N □ Abn		Referrals
Neck -	□ N □ Abn		
Eyes	□ N □ Abn		Developmental Dental
Red Reflex	□ N □ Abn		Other
Dcular Alignment	□ N □ Abn		
ars	□ N □ Abn		
lose	□ N □ Abn		Birth to Three (BTT) 1-800-642-9704
Dral Cavity/Throat	□ N □ Abn		Children with Special HealthCare Needs (CSHCN)
ung	□ N □ Abn		
Heart	□ N □ Abn		□ Women, Infants and Children (WIC) 1-304-558-0030
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn		— Medical Necessity
Genitalia	□ N □ Abn		— For treatment plans requiring authorization, please complete
Back	□ N □ Abn		— page 3. Contact a HealthCheck Regional Program Specialist for
lips	□ N □ Abn		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Extremities	□ N □ Abn		_
Signs of Abuse/Neg	lect □ Yes □ No		— 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 HEALT

Screen Date Early and Periodic S	West Vi 3 Screening, Diagnosis, and	irginia Department of Hea Freatment (EPSDT) Health		ram Preve	ntive Health Screer	24 Month Form
Name						
Weight Height BMI HC	2 Pulse	BP (optional)	Resp_		Temp	Pulse Ox (optional)
Allergies D NKDA						
Current meds Done						
Foster child Kinship	placement		_ □ Child with	special he	alth care needs	
Accompanied by Parent Grandparent Foster parent	Foster organization			□ (Other	
Medical History I Initial screen Family health history reviewed	How much stress are you a I None I Slight I Mode What kind of stress? (✓ C	erate		□ Child c	nental Surveillance (an play alongside oth	\checkmark Check those that apply) er children, also called parallel play
Parental history of postpartum depression	□ Child care □ Drugs □ A _ emotional and/or sexual) □	mily and/or friends) □ Schoo Ncohol □ Violence/abuse (pł I Family member incarcerated oney □ Emotional loss □ H	hysical, d □ Lack of	spoon □ short phra	Child can use 50 wor ase or sentence □ Ch	ing ☐ Child can scoop well with a ds ☐ Child can combine 2 words into nild can follow 2-step command dy parts, such as nose and hand
In utero substance exposure				□ Child's	speech is 50% under	standable to strangers
Child currently receiving mental/behavioral health services? □ Yes □ No	-			run with c □ Child c	oordination □ Child o an stack objects □ C	f the ground with 2 feet ☐ Child can can climb up a ladder at a playground hild can turn book pages ☐ Child can ts like knobs, toys, and lids ☐ Child
Child recent injuries, surgeries, illnesses, visits to other providers and or hospitalizations:	 Does your child seem sad o Not at all Somewhat 	□ Very much r unhappy?	rtain wav?	can draw		
Psychosocial/Behavioral What is your family's living situation?	 Not at all Somewhat Does your child have a hard Not at all Somewhat Does your child break things 	□ Very much I time with change? □ Very much s on purpose?	itali way :	D M-CHA	n screening complet \T-R/F □ Other tool_ n child's record □ \	
Family relationships Good Okay Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? Yes No	 Is your child aggressive? 	l time calming down? □ Very much				
Who do you contact for help and/or support?	 D Not at all D Somewhat Is it hard to take your child c 	out in public?		Genera □ Growth	i Health i plotted on growth cha	art
Are you and/or your partner working outside home? □ Yes □ No Child care	 □ Not at all □ Somewhat Is it hard to know what your □ Not at all □ Somewhat 	child needs?			ink your child sees ok ink your child hears o	5
Child has ability to separate from parents/caregivers □ Yes □ No				Oral Heal		
Child exposed to	_			Current o	st dental visit ral health problems urce □ Public □ We	
□ 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	9			Fluoride s Fluoride v	supplementation □ Yo varnish applied <i>(apply</i> No	es 🗆 No
Do you utilize a car seat for your child? □ Yes □ No □ Excessive television/video game/internet/cell phone use	-			Continu	ie on page 2	West Virginia Department of HEALTH

Screen	Date
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creen Date			24 Month Form, Page 2
Name		DOB	Age Sex: 🗆 M 🗆 F
Nutrition/Sleep Normal eating habits Fruits/vegetables/lean protein po Vitamins Normal elimination Toilet trained □ Yes □ No	er day	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	Plan of Care Assessment Well Child Other Diagnosis Immunizations UTD Given, see immunization record
□ Normal sleeping patterns Hours of sleep each night?		Questions/Concerns/Notes	Labs □ Hemoglobin/hematocrit (if high risk) □ Blood lead (required at 24 months) (enter into WVSIIS)
*Anemia Risk (Hemoglobin/He *Lead Risk Blood lead required at 24 mor *Tuberculosis Risk	ematocrit)		 Block lead (required at 24 months) (enter into wv Sirs) I TB skin test (if high risk) I Lipid profile (if high risk) I Hepatitis B Screen (HBsAG) (if high risk) Other
*Dyslipidemia Risk *Hepatitis B Risk *See Periodicity Schedule for	□ Low risk □ High risk □ Low risk □ High risk		Referrals □ Developmental □ Dental □ Blood lead ≥5ug/dl
Physical Examination (N=			□ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 □ Other
General Appearance I N Skin I N Neurological I N Reflexes I N	Abn Abn Abn Abn Abn		 □ 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
Neck IN Eyes IN Red Reflex IN Ocular Alignment IN	Abn Abn Abn Abn Abn Abn Abn		 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.
NoseINOral Cavity/ThroatINLungINHeartIN	Abn Abn Abn Abn Abn		Follow Up/Next Visit
AbdomenINGenitaliaINBackIN	Abn Abn Abn Abn		□ Screen has been reviewed and is complete
Extremities	Abn Abn		Signature of Clinician/Title
orgina or Abuadinografi			West Virginia Department of

Screen Date		West Virginia Department of Health Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen								
Name			DOB		Age	_ Sex: □ N	/ □ F Race/Ethnic	sity		
Weight	Height	BMI	Pulse	BP	Resp		Temp	Pulse Ox (optional)		
Allergies D NKDA	۰ <u>ـــــ</u>									
Current meds D N	lone									
□ Foster child		🗆 Kins	hip placement			□ Child wit	th special health care	needs		
Accompanied by	□ Parent □ Grandpa	arent D Foster parent	□ Foster organization_				D Other			
Medical History I Initial screen I Family health hi	□ Periodic screen		□ None □ Slight What kind of stree □ Relationships (p	☐ Moderate ss? (✓ Check th partner, family a	nose that apply) nd/or friends) □ School/w		Standardized Scree	tool		
In utero substance exposure □ Yes □ No Child currently receiving mental/behavioral health services? □ Yes □ No		emotional and/or s support/help □ Fi	□ 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			Results in child's rec	ord 🗆 Yes 🗆 No			
		to other providers and/o	r	·						
			— Does your child se □ Not at all □ So □ Does your child se	mewhat 🛛 Ver	y much		, ,	ild sees okay? □ Yes □ No		
Psychosocial/E What is your family	Sehavioral 's living situation?		□ Not at all □ Sol — Does your child ge	mewhat □ Ver t upset when th	y much ings are not done a certai	in way?	Oral Health	ild hears okay? □ Yes □ No		
Do you have conce	Family relationships		 Does your child ha 	ve a hard time v mewhat □ Ver ve trouble playi	with change? y much ng with other children?		Date of last dental visit Current oral health problems Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No			
Who do you contac	t for help and/or supp	ort?	Does your child bro	 □ Not at all □ Somewhat □ Very much □ Does your child break things on purpose? □ Not at all □ Somewhat □ Very much 				lied (apply every 3 to 6 months)		
Child care		ide home? □ Yes □ No /caregivers □ Yes □ No	Does your child ha	ive a hard time o mewhat □ Ver	calming down?		Nutrition/Sleep Normal eating hab Fruits/vegetables/lea	bits n protein per day		
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 with wisherse (abuse			□ Not at all □ So Is it hard to take yo □ Not at all □ So Is it hard to know y □ Not at all □ So	mewhat □ Ver our child out in p mewhat □ Ver vhat your child r	ublic? / much eeds?		□ Vitamins □ Normal elimination Toilet trained □ Yes □ No □ Normal sleeping patterns Hours of sleep each night?			
	□ Witnessed violence/abuse □ Threatened with violence/abuse □ Scary experience that your child cannot forget			ur child to obey mewhat □ Ver						
-	seat for your child? I sion/video game/interr									

Continue on page 2



ame				DOB	Age Sex: 🗆 M 🗆
Anomia Bick (Homo	alahin/U	omotoorit)		Ana Annuanista Haalth Education (Anticipatan)	Dian of Corre
	giobili/He	ematocht)	Low risk High risk	Age Appropriate Health Education/Anticipatory	Plan of Care
Lead Risk			□ Low risk □ High risk	Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment U Well Child D Other Diagnosis
Tuberculosis Risk			□ Low risk □ High risk	<i>information: https://brightfutures.aap.org)</i> Social Determinants of Health, Temperament and Behavior,	
Hepatitis B Risk			□ Low risk □ High risk	Assessment of Language Development, Toilet Training, and Safety	Immunizations
*See Periodicity Sch	edule for	Risk Facto	ors	□ Discussed □ Handouts Given	□ UTD □ Given, see immunization record □ Entered into WVSIIS
					Labs
				Questions/Concerns/Notes	Hemoglobin/hematocrit (if high risk)
Physical Examina	ation (N=	=Normal. A	bn=Abnormal)		_ □ Blood lead (if not completed at 12 and/or 24 months or high risk)
-					_ (enter into WVSIIS)
Skin		Abn			_ □ TB skin test (<i>if high risk</i>)
		Abn			_ □ Hepatitis B Screen (HBsAG) <i>(if high risk)</i>
Neurological Reflexes					_ Other
		Abn			-
Head					- Referrals
Neck		Abn			□ Developmental □ Dental
Eyes		Abn			□ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Red Reflex		Abn			□ Other
Ocular Alignment					
Ears		Abn	_,		-
Nose		Abn			_ □ Children with Special HealthCare Needs (CSHCN)
Oral Cavity/Throat		Abn	_,,		1-800-642-9704
Lung		Abn			□ Women, Infants and Children (WIC) 1-304-558-0030
Heart		Abn			□ Birth to Three (BTT) transition planning
Pulses		Abn			
Abdomen		Abn			Medical Necessity
Genitalia		Abn			For treatment plans requiring authorization, please complet
Back		Abn			page 3. Contact a HealthCheck Regional Program Specialist for
⊣ips Extremities					assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Signs of Abuse/Negl	eci	□ Yes □	INU		Follow Up/Next Visit
					Other
					Screen has been reviewed and is complete
		· · · · · · · · · · · · · · · · · · ·			
					Please Print Name of Facility or Clinician
					Signature of Clinician/Title
	• • • • • • • • •				
					West Virginia
					HEALT

Screen Date_

30 Month Form, Page 2

Screen Date	West Virginia Department of Health Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen								
Name						thnicity			
Weight Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)			
Allergies D NKDA									
Current meds D None									
Foster Child	_ □ Kinship Placement		_ □ Child with specia	I health care needs	O IE	P/section 504 in place			
Accompanied by D Parent D Grandpar	ent □ Foster parent	□ Foster organization			□ Other				
Oral Health Date of last dental visit Current oral health problems Water source Public Water source Public Water source Public Vuoride supplementation Yes Pes No Vision Acuity Screen: □ R □ Wears glasses? Yes No □ Hearing Screen (Subjective screen requined to you think your child hears okay? Yes No □	ed 6 months) O (retest in 6 months) red)	☐ Child can enter can put on coat, ja independently ☐ play in cooperatior ☐ Child can speak ☐ Child can tell yo things using words simple preposition ☐ Child can climb forward ☐ Child c with head and 1 of	urveillance (✓ Check bathroom and urinate cket or shirt by thems Child can engage in in a and share □ Child c in words that are 75% ou a story from a book blike bigger or shorter s, such as on or unde on and off couch or cl an draw a single circle	by himself/herself Child can eat naginative play Child can eat naginative play Child can eat ause 3 word sentences understandable to stran or TV Child can understand Child can understand Child can pedal a tric hair Child can draw a per d can cut with child scisso	Image: Constraint of the state of the s	health/trauma - Help4WV.com/1-844-435-7498 OO □ Hearing Initial HealthCare Needs (CSHCN) ial HealthCare Needs (CSHCN) Initial HealthCare Needs (CSHCN) d Children (WIC) 1-304-558-0030 Initial HealthCare Needs (CSHCN) of Facility or Clinician Initial HealthCare Needs (CSHCN)			
	The infor	mation above this line	is intended to be r	eleased to meet schoo	l entry requirements	~~~~~~			
Medical History Initial Screen Periodic Screen Family health history reviewed				asic family needs daily an∉ Yes □ No	^{α/or} □ Excessive televisio	ooster seat for your child? □ Yes □ No n/video game/internet/cell phone use			
In utero substance exposure □ Yes □ No Child currently receiving mental/behavioral health services? □ Yes □ No		Child care/after sc Is your child in sch Favorite thing abo Any problems? Activities outside s	hool care lool?	side home? □ Yes □ No	□ None □ Slight □ What kind of stress? □ Relationships (part □ Child care □ Drug □ emotional and/or sexu support/help □ Finar	e you and your family under <u>now</u> ? 1 Moderate □ Severe ? (✓ <i>Check those that apply</i>) ner, family and/or friends) □ School/work Is □ Alcohol □ Violence/abuse (physical, ual) □ Family member incarcerated □ Lack of ncial/money □ Emotional loss □ C			
Psychosocial/Behavioral What is your family living situation Family relationships □ Good □ Okay □	Poor	Child exposed to Drugs (prescrip) Access to firear Are the firearm(s)/ Witnessed viole	□ Cigarettes □ E-C tion or otherwise) m(s)/weapon(s) □ weapon(s) secured?	Cigarettes/Vaping □ Alco □ Has a firearm(s)/weapo □ Yes □ No □ NA reatened with violence/ab	hol	West Virginia			

Continue on page 2



Age Sex: D M D 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 (<u>https://hipaa.jotform.com/</u> <u>PGHN/help4wv-PCP-referral</u>).

- □ 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? Li Yes Li No		
Fruits/vegetables/lean protein per day_		
□ Vitamins		
Normal elimination		
D Physical activity/exercise an hour me	ost 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

*See Periodicity Schedule for Risk Factors

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance	\Box N	Abn	
Skin	\Box N		
Neurological	\Box N	🗆 Abn	
Reflexes	\Box N	□ Abn	
Head	\Box N		
Neck	\Box N	🗆 Abn	
Eyes	\Box N	🗆 Abn	
Red Reflex	\square N	🗆 Abn	
Ocular Alignment	\square N	🗆 Abn	
Ears	\Box N	□ Abn	
Nose	\Box N	□ Abn	
Oral Cavity/Throat	\Box N		
Lung	\Box N		
Heart	\Box N	□ Abn	
Pulses	\Box N	□ Abn	
Abdomen	\Box N	□ Abn	
Genitalia	\Box N	□ Abn	
Back	\Box N		
Hips	\Box N	□ Abn	
Extremities	ΠN		

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 I Handouts Given

Plan of Care

Assessment

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



Screen Date Early and Periodic So	West Virginia Departr creening, Diagnosis, and Treatment (EP		rogram Pi	reventive H	lealth Sc	4 Year Form
- Name						
Weight Height BMI	Pulse BP	Resp	1	Temp		Pulse Ox (optional)
Allergies D NKDA						
Current meds Done						
Foster Child Kinship Placement					v/section 5	504 in place
Accompanied by □ Parent □ Grandparent □ Foster parent □ Fo	oster organization			□ Other		
Oral Health Date of last dental visit Current oral health problems Water source Public Public Well Tested Fluoride supplementation Yes No Fluoride varnish applied (apply every 3 to 6 months) Yes No Vision Acuity Screen: R Wears glasses? Yes No Hearing Screen 20 db@ UTO (retest in 6 months) R ear 500HZ R ear 1000HZ 2000HZ 4000HZ L ear 1000HZ 2000HZ 4000HZ	Developmental Surveillance (✓ Check tho. □ Child can enter bathroom and have a box herself □ Child can brush his/her teeth □ undress without much help □ Child can envi imaginative play □ Child can answer simpl speak in words that are 100% understandat can draw pictures that you recognize □ Ch when playing games □ Child can tell you a □ Child can skip on 1 foot □ Child can clim without support □ Child can draw a person □ Child can draw a simple cross □ Child c medium sized buttons □ Child can grasp p fingers instead of fist □ Concerns about child's behavior, speech skills	vel movement by himse Child can dress and gage in well-developed e questions Child ca ble to strangers Child ca ble to strangers Child id can follow simple ru story from a book ab stairs, alternating fee with at least 3 body pa an unbutton and buttor encil with thumb and learning, social or mot	Leff/ Refe An Define Id Off Iles Cr I-800 et, Wr Arts N Pleas	TD □ Given rrals : □ Devental/behavio ental □ Visio ther ii ldren with \$ 0-642-9704 omen, Infant	n, see imm velopment oral health on □ Hea Special Hea ts and Chi me of Fac	of trauma - Help4WV.com/1-844-435-7498 aring calthCare Needs (CSHCN) ildren (WIC) 1-304-558-0030 cility or Clinician
Wears hearing aids? □ Yes □ No						>
	on above this line is intended to be relea	ised to meet school	entry req	uirements		
Medical History Initial Screen Family health history reviewed	Do you have concerns about meeting basic monthly (food, housing, heat, etc.)?		,			r seat for your child? □ Yes □ No eo game/internet/cell phone use
In utero substance exposure	Are you and/or your partner working outside Child care/after school care		🗆 No	one 🛛 Sligh	ht □ Mod	and your family under <u>now</u> ? lerate Severe <i>Check those that apply)</i>
Child currently receiving mental/behavioral health services? Yes No Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Is your child in school?		□ Cł emot supp	nild care □ ional and/or	Drugs □ / sexual) □ Financial/n	amily and/or friends) □ School/work Alcohol □ Violence/abuse (physical, □ Family member incarcerated □ Lack of noney □ Emotional loss □ Health
Psychosocial/Behavioral What is your family living situation	Child exposed to □ Cigarettes □ E-Ciga □ Drugs (prescription or otherwise) □ □ Access to firearm(s)/weapon(s) □	rettes/Vaping □ Alcoh as a firearm(s)/weapon				
Family relationships □ Good □ Okay □ Poor	Are the firearm(s)/weapon(s) secured? I Y Witnessed violence/abuse I Threat Scary experience that your child cannot f	ened with violence/abu	use Con	itinue on⊺	page 2	West Virginia Department of HEALTH

DOB

Age_____ Sex: D M D 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 (<u>https://hipaa.jotform.com/</u> <u>PGHN/help4wv-PCP-referral</u>).

- □ 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	Hea	lth
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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							
D Physical activity/exercise an hour mo	ost 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							
*Dyslipidemia Risk							
*Hepatitis B Risk	□ Low risk	□ High risk					

*See Periodicity Schedule for Risk Factors

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance	\Box N	Abn	· · · · · · · · · · · · · · · · · · ·
Skin	\Box N	□ Abn	
Neurological	\Box N	□ Abn	
Reflexes	\Box N		
Head	\Box N		
Neck	\Box N		
Eyes	\Box N	□ Abn	
Red Reflex	\Box N		
Ocular Alignment	\Box N		
Ears	\Box N	🗆 Abn	
Nose	\Box N	🗆 Abn	
Oral Cavity/Throat	\Box N	🗆 Abn	
Lung	\Box N		
Heart	\Box N	□ Abn	
Pulses	\Box N		
Abdomen	\Box N	□ Abn	
Genitalia	\Box N	□ Abn	
Back	\Box N	🗆 Abn	
Hips	\Box N		
Extremities	\Box N		

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

UWell Child Other Diagnosis

Labs

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.

□ Screen has been reviewed and is complete

See page 1, school requirements for required signature



Name	creening, Diagnosis, and Treatment (EPS		-	
Weight Height BMI				
Current meds Done				······································
Foster Child Kinship Placement	□ Child with special hea	Ith care needs	□ IEP/secti	on 504 in place
Accompanied by □ Parent □ Grandparent □ Foster parent □ F	oster organization		□ Other	
Oral Health	Developmental		Immunizations: Attach cu	rrent immunization record
Date of last dental visit	Developmental Surveillance (e that apply)	□ UTD □ Given, see imr	nunization record D Entered into WVSIIS
Current oral health problems	□ Child can balance on one foot, hops and s	skips		
Water source □ Public □ Well □ Tested	□ Child is able to tie a knot, has mature pen	cil grasp, can draw a	Referrals: Developmen	
Fluoride supplementation D Yes D No	person with at least 6 body parts, prints som	e letters and numbers		n/trauma - Help4WV.com/1-844-435-7498
Fluoride varnish applied (5 years, apply every 3 to 6 months)	and is able to copy squares and triangles		□ Dental □ Vision □ He	earing
□ Yes □ No	□ Child has good articulation, tells a simple		Other	
Vision Acuity Screen:	sentences, uses appropriate tenses and pro- and names at least 4 colors	nouns, can count to 10,	LI Children with Special He	ealthCare Needs (CSHCN)
RL	□ Child follows simple directions, is able to I	isten and attend and		sility or Clinician
Vears glasses? □ Yes □ No	undresses and dresses with minimal assista			
			Please Print Name of Fac	cility or Clinician
Hearing Screen	□ Concerns about child's speech, learning, o	or motor skills		
20 db@ Bear 50047 Bear 100047 200047 400047			Signature of Clinician/Tit	
R ear 500HZ_R ear 1000HZ 2000HZ 4000HZ L ear 500HZ_L ear 1000HZ 2000HZ 4000HZ				le
Nears hearing aids? \Box Yes \Box No				
	ion above this line is intended to be relea	sed to meet school e		}
Medical History	Do you have concerns about meeting basic	family needs daily and/or		r seat for your child? □ Yes □ No
□ Initial Screen	monthly (food, housing, heat, etc.)?		Does your child wear prote	ective gear, including seat belts?
Family health history reviewed			- □ Yes □ No	
	Are you and/or your partner working outside	home? □ Yes □ No		eo game/internet/cell phone use
	Child care/after school care		- How much stross are you	and your family under <u>now</u> ?
				· · <u> </u>
n utero substance exposure	Child's grade in school		- What kind of atrage? (//	
Child currently receiving mental/behavioral health services?	Favorite subject			family and/or friends)
□ Yes □ No Recent injuries, surgeries, illnesses, visits to other providers and/or	Any problems?			Alcohol D Violence/abuse (physical,
nospitalizations:	Activities outside school Peer relationships/friends □ Good □ Okay	D Door		□ Family member incarcerated □ Lack of
				noney 🛛 Emotional loss 🛛 Health
	Child exposed to Cigarettes E-Cigar	ettes/Vaping □ Alcohol	insurance D Other	
Psychosocial/Behavioral	□ Drugs (prescription or otherwise)	·····	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·
What is your family living situation		s a firearm(s)/weapon(s)		
	Are the firearm(s)/weapon(s) secured?			
Family relationships 🗆 Good 🗖 Okay 🗖 Poor		ened with violence/abuse	e Continue on page 2	
	□ Scary experience that your child cannot for	orget	_	West Virginia
			-	Department of
				HEALTH

Age Sex: D M D 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 (<u>https://hipaa.jotform.com/</u> <u>PGHN/help4wv-PCP-referral</u>).

- 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

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? D Yes D	No							
Hours of sleep each night?								
*Anemia Risk (Hemoglobin/Hematocrit)		□ High risk						
*Lead Risk	□ Low risk	□ High risk						
*Tuberculosis Risk	□ Low risk	□ High risk						
Dyslipidemia Risk <i>(year 6)</i>								
*Hepatitis B Risk	Low risk	□ High risk						

DOB

*See Periodicity Schedule for Risk Factors

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance	$\Box N$	□ Abn	
Skin	\Box N		
Neurological	\Box N	□ Abn	
Reflexes	\Box N	□ Abn	
Head	\Box N		
Neck	\Box N		
Eyes	\Box N	□ Abn	
Ocular Alignment	\Box N	🗆 Abn	
Ears	\Box N		
Nose	\Box N	□ Abn	
Oral Cavity/Throat			
Lung	\Box N	□ Abn	
Heart	\Box N	□ Abn	
Pulses	\Box N	□ Abn	
Abdomen	\Box N	□ Abn	
Genitalia	\Box N	□ Abn	
Back	\Box N	□ Abn	
Hips	\Box N	□ Abn	
Extremities	\Box 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

UWell Child Other Diagnosis

Labs

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

General Health

Growth plotted on growth chartBMI calculated and plotted on BMI chart



Creen Date Early and Periodic S	West Virginia Department of Health creening, Diagnosis, and Treatment (EPSDT) HealthCheck Prog	gram Preventive Health Screen 7 and 8 Year Form
-		Sex: □ M □ F Race/Ethnicity
Weight Height BMI	Pulse BP Resp	Temp Pulse Ox (optional)
Allergies 🗆 NKDA		
Current meds		
		□ IEP/section 504 in place
Accompanied by Parent Grandparent Foster parent F	oster 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	Hearing Screen 20 db@ R ear500HZ R ear1000HZ 2000HZ 4000HZ L ear500HZ L ear1000HZ 2000HZ 4000HZ Wears hearing aids? □ Yes □ No	□ Other □ Children with Special HealthCare Needs (CSHCN)
Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No	Developmental Surveillance Concerns about child's speech, learning, or motor skills	Please Print Name of Facility or Clinician Signature of Clinician/Title
Vision Acuity Screen: RL Wears glasses? □ Yes □ No		Please Print Name of Facility or Clinician
	above this line is intended to be released to meet school entry	×
Medical History □ Initial Screen □ Periodic Screen □ Family health history reviewed	Are parents/caregivers working outside home? □ Yes □ No Child care/after school care	How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply)
Currently receiving mental/behavioral health services? Ves No	Grade in school Favorite subject Any problems? Activities outside school	□ 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
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Peer relationships/friends □ Good □ Okay □ Poor Exposure to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise)	insurance Other
Psychosocial/Behavioral What is your family living situation	□ 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	
Family relationships □ Good □ Okay □ Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No	Does your child wear protective gear, including seat belts? □ Yes □ No □ Excessive television/video game/internet/cell phone use	Continue on page 2
		HEALTH

DOB

Age Sex: D M D 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 (<u>https://hipaa.jotform.com/</u> 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	ΠN	□ Abn	
Skin			
Neurological	\Box N	□ Abn	
Reflexes	\Box N	□ Abn	
Head	\Box N		
Neck	\Box N		
Eyes	\Box N	□ Abn	
Ears			
Nose	\Box N	□ Abn	
Oral Cavity/Throat	\Box N	□ Abn	
Lung	\Box N	□ Abn	
Heart	\Box N	□ Abn	
Pulses	\Box N	□ Abn	
Abdomen	\Box N	□ Abn	
Genitalia	\Box N	□ Abn	
Back	\Box N	□ Abn	
Hips	\Box N	□ Abn	
Extremities	\Box 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

UWell Child Other Diagnosis

Labs

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



Screen Date Early and Periodic S	West Virginia Dep creening, Diagnosis, and Treatment (9 and 10 Year Forn gram Preventive Health Screen
- Name			-
Weight Height BMI	Pulse BP	Resp	Temp Pulse Ox (optional)
Allergies D NKDA			
Current meds			
Foster Child Kinship Placement	□ Child with spec	cial health care needs	□ IEP/section 504 in place
Accompanied by □ Parent □ Grandparent □ Foster parent □ F	oster organization		□ Other
Medical History	Concerns about speech, learning, socia	Il or motor skills	Frequent use of profane, vulgar, or curse words to household members
Family health history reviewed	Concerns about depression and/or anxi	ety	 Deliberate damage to home Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
Currently receiving mental/behavioral health services? Yes No	Traumatic Stress Reactions/PCL-C *Positive screen = numbered respons	-	 Marked changes in moods that are generally intense and abrupt Friendships change to mostly substance users
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Feelings over the past 2 weeks: (✓ Constrained of the past 2 weeks) (✓ Constrained of the past 2 week	ts, or images of a Not at all (0) □ A little bit (1)	 Preoccupying cognitions or fantasies with bizarre, odd, or gross themes Currently at risk of confinement because of frequent or serious violations of law
Psychosocial/Behavioral What is your family living situation	Feeling very upset when something rem experience from the <u>past</u> ? □ Not at all □ Moderately (2) □ Quite a bit (3) □	(0) A little bit (1)	Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources
Family relationships □ Good □ Okay □ Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No	□ None □ Slight □ Moderate □ Se What kind of stress? (✓ Check those t	of stress? (✓ Check those that apply) ships (partner, family and/or friends) □ School/work □ Alcohol □ Violence/abuse (physical, emotional and/or Family member incarcerated □ Lack of support/help II □ Emotional loss □ Health insurance	General Health Growth plotted on growth chart BMI calculated and plotted on BMI chart Nutrition/Physical Activity/Sleep
Are parents/caregivers working outside home? Yes No Child care/after school care	sexual)		Normal eating habits?
Grade in school	Other		□ Normal elimination
Favorite subject Any problems?			Physical activity/exercise an hour most days Type of physical activity/exercise
Activities outside school Peer relationships/friends	Indicators of Serious Emotiona Disturbance (✓ Check those that ap		Normal sleeping patterns? □ Yes □ No
Exposure to Cigarettes E-Cigarettes/Vaping Alcohol Drugs (prescription or otherwise)	If any indicator is selected, referral to Referral Line is recommended (<u>https:/</u> help4wv-PCP-referral).	o the Children's Crisis and	Hours of sleep each night? Oral Health Date of last dental visit
□ Access to firearm(s)/weapon(s) □ Has a firearm(s)/weapon(s) Are the firearm(s)/weapon(s) secured? □ Yes □ No □ NA	 Talks or repeatedly thinks about harr 	ming self, killing self, or	Current oral health problems Water source
□ 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	wanting to die Frequently mean to other people or a Family conflict is pervasive and continue of the second se		Fluoride supplementation Yes No Vision Acuity Screen: (Objective 10 years)
	 hostility, tension, and/or scapegoatin Behavior frequently typically inappro for self or others (i.e., fighting, bellig 	ng, etc.) priate and causes problems	RL Wears glasses? Ves No West Virginia
	()	, ,, , , , , , , , , , , , , , , , , ,	Continue on page 2

ame			DOB	Age Sex: 🗆 M 🗆
Hearing Screen (Obj	ective 10 years)		Age Appropriate Health Education/Anticipatory	Plan of Care
20db@	4000117		Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment
R ear: 500HZ	1000HZ	2000HZ4000HZ	information: https://brightfutures.aap.org)	Well Child Other Diagnosis
		2000HZ 4000HZ	Social Determinants of Health, Development and Mental Health,	
Vears hearing aids?	LI YES LI NO		School, Physical and Growth Development, and Safety	Immunizations
			Discussed I Handouts Given	□ UTD □ Given, see immunization record □ Entered into WVS
*Anemia Risk (Hemog	lobin/Hematocrit)	□ Low risk □ High risk		Labs
Tuberculosis Risk		□ Low risk □ High risk	Questions/Concerns/Notes	Hemoglobin/hematocrit (if high risk)
*Dyslipidemia Risk Fasting lipoprotein req	uired once betwee	□ Low risk □ High risk In 9 and 11 years		 TB skin test (if high risk) Fasting lipoprotein (once between 9 and 11 years and/or high risk)
*Hepatitis B Risk		□ Low risk □ High risk		□ Hepatitis B Screen (HBsAG) <i>(if high risk)</i> □ Other
*See Periodicity Sch	edule for Risk F	Factors		
Physical Examin	ation (N-Norma	al Abr-Abrormal)		Referrals
General Appearance		ai, Abii–Abiioimai)		Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Skin				□ Dental □ Vision □ Hearing
Neurological				□ Other
Reflexes	□N □ Abn			
Head	□N □ Abn			
Neck	□N □ Abn			Children with Special HealthCare Needs (CSHCN)
Eyes	□N □ Abn			1-800-642-9704
Ears	□N □ Abn			
Nose	□N □ Abn			
Oral Cavity/Throat	□N □ Abn			Medical Necessity
_ung	□N □Abn			For treatment plans requiring authorization, please complete
Heart	□N □Abn _			page 3. Contact a HealthCheck Regional Program Specialist for
Pulses	□N □Abn _			assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Abdomen	□N □Abn _			
Genitalia	□N □Abn _			
Back	□N □Abn _			Follow Up/Next Visit
Hips	□N □Abn _			□ Other
Extremities	□N □Abn _			
If female:				Screen has been reviewed and is complete
LMP	🗆 Regula	ar 🛛 Irregular		
Bleeding	🗆 Normal 🗆 He	5		
Cramping	□ No □ Slight I	□ Severe		
Possible Signs of Al	ouse/Neglect □	Yes 🗆 No		Please Print Name of Facility or Clinician
				Signature of Clinician/Title
				- West Virainia
				Pepartment of HEALT

Screen Date	Early and Period	11, 12, 13 and 14 Year Form th Screen				
Name						hnicity
Weight Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (<i>optional</i>)
Allergies 🗆 NKDA						
Current meds						
Foster Child	🛛 Kinship Placen	nent	□ Child with sp	ecial health care needs	O IEF	P/section 504 in place
Accompanied by D Parent D Grandparer	t □ Foster parent	□ Foster organization			□ Other	
Immunizations: Attach current immunizati UTD Given, see immunization record Oral Health Date of last dental visit	□ Entered into WV	SIIS 20db@ R ear: 500	Dbjective, once betwee HZ 1000HZ HZ 1000HZ	n 11 and 14 years) _2000HZ 4000HZ _2000HZ 4000HZ		ç 11
Current oral health problems Water source		R ear: 600 L ear: 6000 Wears hearing aids	0HZ 8000HZ		□ Family Planning Pr	rogram (FPP) 1-800-642-9704 iial HealthCare Needs (CSHCN)
Vision Acuity Screen: (Objective 12 years) RL Wears glasses? □ Yes □ No		Developmental Concerns about sp	Surveillance eech, learning, social a	and/or motor skills	Please Print Name c	of Facility or Clinician
					Signature of Clinicia	an/Title is in the second s
	The inform	ation above this line is	intended to be relea	sed to meet school ei	ntry requirements	X
Medical History Initial Screen Periodic screen Family health history reviewed		Any problems Activities outside school Peer relationships/friends		ay □ Poor	Traumatic Stress Re <i>*Positive screen = n</i> Feelings over the pa	umatic Stress Reactions/PCL-C positive screen = numbered responses 4 or greater plings over the past 2 weeks: (✓ Check one for each question) poeated, disturbing memories, thoughts, or images of a
Currently receiving mental/behavioral health	services? 🗆 Yes 🗆				□ Moderately (2) □	from the <u>past</u> ? □ Not at all (0) □ A little bit (1) Quite a bit (3) □ Extremely (4) nen something reminded you of a stressful
Recent injuries, surgeries, illnesses, visits to hospitalizations:	•	^{/or} *If positive see Pe —— and /or SBIRT scr	<pre>*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</pre>			past? □ Not at all (0) □ A little bit (1) Quite a bit (3) □ Extremely (4)
Psychosocial/Behavioral What is your family living situation		Are the firearm(s)/v U Witnessed violer Do you wear protect				Patient Health Questionnaire (PHQ-2) numbered responses 3 or greater odicity Schedule for link to PHQ-9 ast 2 weeks: (Check one for each question)</td
Family relationships Good Okay P Do you have concerns about meeting basic monthly (food, housing, heat, etc.)? Yes	family needs daily ar □ No	nd/or <i>(13 and 14 years)</i> Are you in a relatio				sure in doing things:
Are parents/caregivers working outside hom Child care/after school care Grade in school Favorite subject					Continue on pag	e 2 West Virginia Department of HEALTH

How much stress are you and your family under now? □ None □ Slight □ Moderate □ Severe What kind of stress? (\checkmark Check those that apply) □ Relationships (partner, family and/or friends) □ School/work □ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/ 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?

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, 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 :	
Fruits/vegetables/lean	protein per dav

□ Vitamins

Normal elimination

Physical activity/exercise an hour most days

Type of physical activity/exercise

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 betwee		☐ High risk ars
*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	\Box N	□ Abn
Skin	\Box N	
Neurological	\Box N	□ Abn
Reflexes	\Box N	
Head	\Box N	□ Abn
Neck	\Box N	□ Abn
Eyes	\Box N	□ Abn
Ears	\Box N	□ Abn
Nose	\Box N	□ Abn
Oral Cavity/Throat		□ Abn
Lung	\Box N	□ Abn
Heart	\Box N	□ Abn
Pulses	\Box N	
Abdomen	\Box N	
Genitalia	\Box N	□ Abn
Back	\Box N	□ Abn
Hips	\Box N	
Extremities	\Box 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 Handouts Given Discussed

Plan of Care

Assessment

U Well Child Visit Other Diagnosis

Labs

 Hemoglobin/hematocrit (*if high risk*) □ TB skin test (if high risk) Exactly Fasting lipoprotein (once between 9 and 11 years and/or high risk) □ STI test (if sexually active and/or high risk) \Box 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



Screen Date Early and Periodic		•	epartment of Health nt (EPSDT) HealthCheck P	rogram Preventive	Health Screen	15, 16 and 17 Year Form
Name	DOB		Age	Sex: DM DF R	ace/Ethnicity	
Weight Height BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)
Allergies D NKDA						
Current meds Done						· · · · · · · · · · · · · · · · · · ·
□ Foster Child□ Kinship Placement		_□ Child with speci	ial health care needs	C	IEP/section 504 in place_	
Accompanied by DN/A DParent DGrandparent DFoster pa	rent D Foster organiz	ation		0	Other	
Immunizations: Attach current immunization record UTD Given, see immunization record Entered into WVSII Oral Health Date of last dental visit	S 20db@ R ear: 500	HZ 1000HZ _ HZ 1000HZ _ 0HZ 8000HZ 0HZ 8000HZ s? □ Yes □ No		□ Substance at □ Dental □ Vis □ Other □ Family Plann □ Children with 1-800-642-9704	ing Program (FPP) 1-800- Special HealthCare Need I	-435-7498 OO Entry 542-9704 S (CSHCN) Require
Vision Acuity Screen: (Objective 15 years) R L Wears glasses? Yes No	Concerns about sp skills			Signature of C		nents
The information of the information of the information of the information of the initial Screen The information of the informat			feleased to meet school ei	Traumatic Stre	ess Reactions/PCL-C en = numbered response the past 2 weeks: (Che</td <td>•</td>	•
Currently receiving mental/behavioral health services? Yes No	□ *Tobacco use □ □ □ E-Cigarettes/Va □ *Alcohol use	ping □ *Chew □	day Passive Smoke Risk	stressful experie □ Moderately (2	2) □ Quite a bit (3) □ E	ot at all (0) □ A little bit (1) tremely (4)
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:		eriodicity Schedul reening tools	se) le for links to CRAFFT □ Has a firearm(s)/weapon	experience from	set when something remin n the <u>past</u> ? □ Not at all (0 2) □ Quite a bit (3) □ E) D A little bit (1)
Psychosocial/Behavioral What is your living situation?	Are the firearm(s)/ Witnessed viole Do you wear protect	weapon(s) secured nce/abuse	I? □ Yes □ No □ NA eatened with violence/abuse g seat belts? □ Yes □ No	Depression Sc *Positive scree *If Positive see	reen/Patient Health Ques en = numbered responses Periodicity Schedule for the past 2 weeks: (✓ Che	s 3 or greater link to PHQ-9
Family relationships Good Ckay Poor Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? Yes No		onship? □ Yes (□ ctive? □ Yes □	nternet/cell phone use Male □ Female) □ No No	Little interest or Several days Feeling down, d	pleasure in doing things: □ (1) □ More than ½ the date depressed, or hopeless: □	∃ Not at all (0) ys (2) □ Nearly every day (3)
Are you still in school? □ Yes □ No Working? □ Yes □ No What are your future plans?			No		(,	, , , <u> </u>

Continue on page 2



How much **stress** are you and your family under <u>now</u>? Done Dight Moderate Severe **What kind of stress**? (*< Check those that apply*) Relationships (partner, family and/or friends) Chool/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 (<u>https://hipaa.jotform.com/</u> 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?

In the past week, have you been having thoughts about killing yourself? \Box Yes \Box 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? \Box Yes \Box 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 model	ost days			
Type of physical activity/exercise				
Normal sleeping patterns?	No			
Hours of sleep each night?				
*Anemia Risk (Hemoglobin/Hematocrit) 🛛 Low risk 🖾 High risk				
*Tuberculosis Risk	Low risk	□ High risk		
*Dyslipidemia Risk				
*STI Risk	□ Low risk	□ High risk		
*HIV Risk				
*Hepatitis B Risk	Low risk	□ High risk		

*See Periodicity Schedule for Risk Factors

Physical Examination (N=Normal, Abn=Abnormal)

\Box N	□ Abn		
\Box N	□ Abn		
\Box N	□ Abn		
\Box N	🗆 Abn		
\Box N	□ Abn		
\Box N	□ Abn		
\Box N	□ Abn		
\Box N	□ Abn		
\Box N	□ Abn		
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\Box N	🗆 Abn		
\Box N	🗆 Abn		
\Box N	□ Abn		
\Box N	□ Abn		
\Box N	□ Abn		
	_ 🗆 Regu	ılar 🛛 Irregular	
□ Normal □ Heavy			
🗆 No	□ No □ Slight □ Severe		
		N Abn N <t< td=""></t<>	

Possible Signs of Abuse/Neglect □ Yes □ No

Sudden Cardiac Arrest (SCA) Evaluation

Age

- □ 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 Used 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



Sex: DM DF

Screen Date Early and Periodic S	West Virginia Department of Health creening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Scree					18, 19 and 20 Year Form Screen
Name	DOB		Age	Sex: □ M	□ F Race/Ethnicity	
Weight Height BMI	Pulse	BP		Resp	Temp	Pulse Ox (optional)
Allergies D NKDA						
Current meds Done						
□ 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	Are you in a relations Are you sexually active Method of contracept Do you have children	ve? □ Yes □ tion	No	,	Disturbance (✓ Che If any indicator is sele	us Emotional or Behavioral ck those that apply) cted, referral to the Children's Crisis and mended (<u>https://hipaa.jotform.com/PGHN/</u>
Currently receiving mental/behavioral health services? Ves No					help4wv-PCP-referral).	
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Traumatic Stress Re *Positive screen = n Feelings over the pa Repeated, disturbing	ast 2 weeks: (✓ memories, thoug	onses 4 or Check on ghts, or ima	e for each question) ages of a	wanting to die Frequently mean to Family conflict is per	vasive and continual (characterized by
Psychosocial/Behavioral What is your living situation	stressful experience f Moderately (2) Feeling very upset wh experience from the p Moderately (2)	Quite a bit (3) hen something re past? □ Not at a	□ Extreme eminded yo all (0) □ □	ely (4) ou of a stressful A little bit (1)	 Behavior frequently for self or others (i.e) Frequent use of prof 	d/or scapegoating, etc.) typically inappropriate and causes problems ., fighting, belligerency, promiscuity) ane, vulgar, or curse words to household
Are you in school?					members Deliberate damage t	o home
What are your future plans?	Depression Screen/ *Positive screen = n	numbered respo	onses 3 or	greater	☐ Frequently truant (i.e several consecutive	e., approximately once every 2 weeks or for days)
What interests do you have outside of school and/or work?	*If Positive see Perio Feelings over the pa	ast 2 weeks: (√	Check one	e for each question)	-	noods that are generally intense and abrupt to mostly substance users
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No	Little interest or pleas Several days (1) Nearly every day (2)	☐ More than (3)	¹ ∕₂ the day	s (2)	themes	ions or fantasies with bizarre, odd, or gross onfinement because of frequent or serious
□ *Tobacco use □ Cigarettes # per day □ E-Cigarettes/Vaping □ *Chew □ Passive Smoke Risk □ *Alcohol use	Feeling down, depres □ Several days (1) □ Nearly every day (☐ More than		ot at all (0) s (2)		tal needs cannot be adequately met because opmental demands exceed family resources
 □ *Nortic test	How much stress are None Slight What kind of stress Relationships (part Drugs Alcohol sexual) Family me	☐ Moderate ☐ \$? (✓ <i>Check thos</i> tner, family and/ ☐ Violence/abus	Severe e that appl or friends) se (physica	y) □ School/work II, emotional and/or	off if you were dead?	ve you wished you were dead? □ Yes □ No ve you felt that you or your family would be better Yes □ No u been having thoughts about killing yourself?
Thoughts/plans to harm \Box Self \Box Others \Box Animals \Box NA	□ Financial/money □ □ Other	□ Emotional loss	a □ Health	insurance	If patient answers Yes to any positive screen. Ask the follow	of the above, or refuses to answer, they are considered a ving acuity question:
Do you wear protective gear, including seat belts? ☐ Yes ☐ No ☐ Excessive television/video game/internet/cell phone use						of killing yourself right now? □ Yes □ No Patient required a STAT safety/full mental health
					Continue on page	2 West Virginia Department of

DOB

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
Uitamins
Normal elimination
Physical activity/exercise an hour most days
Type of physical activity/exercise
Normal sleeping patterns?
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 I	nearing aids? 🛛 Y	′es □No		

*Anemia Risk (Hemoglobin/Hematocrit)	□ Low risk	□ High risk
*Tuberculosis Risk	Low risk	□ High risk
*Dyslipidemia Risk Fasting lipoprotein required once betwe		□ High risk years
*STI Risk	Low risk	□ High risk
*HIV Risk HIV test required once between 15 and		□ High risk
Hiv lest 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					
Skin	\Box N	□ Abn			
Neurological	\Box N	□ Abn			
Reflexes	\Box N				
Head	\Box N				
Neck	\Box N				
Eyes	\Box N				
Ears	\Box N	□ Abn			
Nose	\Box N				
Oral Cavity/Throat	\Box N				
Lung	\Box N	□ Abn			
Heart	\Box N				
Pulses	\Box N				
Abdomen	\Box N				
Genitalia	\Box N				
Back	\Box N				
Hips	\Box N				
Extremities	\Box N				
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

Plan of Care

Assessment

U Well Child Other Diagnosis

Immunizations

□ UTD □ Given, see immunization record □ Entered into WVSIIS

Age

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

Works Sourced

Erickson CC, Salerno JC, Berger S, et al; AAP SECTION ON CARDIOLOGY AND CARDIAC SURGERY, PEDIATRIC AND CONGENITAL ELECTROPHYSIO-

OLOGY SOCIETY (PACES) TASK FORCE ON PREVENTION OF SUDDEN DEATH IN THE YOUNG. Sudden Death in the Young Information for the

Primary Care Provider. Pediatrics. 2021; 148(1):e2021052044. https://doi.org/10.1542/peds.2021-052044

Hodges, K. (2000). Child and Adolescent Functional Assessment Scale. Ypsilanti, MI: Eastern Michigan University.

- Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594*.
 Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34*, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.
- Murphy JM, Pagano ME, Ramirez A, et al. Validation of the Preschool and Early Childhood Functional Assessment Scale (PECFAS). Journal of Child and Family Studies. 1999 Sep;8(3):343-356. DOI: 10.1023/a:1022071430660.
- Sheldrick, R. C., Henson, B. S., Neger, E. N., Merchant, S., Murphy, J. M., & Perrin, E. C. (2013). The baby pediatric symptom checklist: development and initial validation of a new social/emotional screening instrument for very young children. *Academic pediatrics*, *13*(1), 72–80.

https://doi.org/10.1016/j.acap.2012.08.003

Sheldrick, R. C., Henson, B. S., Merchant, S., Neger, E. N., Murphy, J. M., & Perrin, E. C. (2012). The Preschool Pediatric Symptom Checklist (PPSC): development and initial validation of a new social/emotional screening instrument. *Academic pediatrics*, *12*(5), 456–467.

https://doi.org/10.1016/j.acap.2012.06.008

