

Screen Date _____

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

15, 16 and 17 Year Form

Name _____ DOB _____ Age _____ Sex: M F

Weight _____ Height _____ BMI _____ Pulse _____ BP _____ Resp _____ Temp _____ Pulse Ox (optional) _____

Allergies NKDA _____

Current meds None _____

Foster Child Kinship Placement Child with special health care needs IEP/section 504 in place _____

Accompanied by N/A Parent Grandparent Foster parent Foster organization _____ Other _____

Immunizations: Attach current immunization record

UTD Given, see immunization record Entered into WVSIIS

Oral Health

Date of last dental visit _____

Current oral health problems _____

Water source Public Well Tested

Fluoride supplementation Yes No

Vision Acuity Screen: (Objective 15 years)

R _____ L _____

Wears glasses? Yes No

Hearing Screen (Objective, once between 15 and 17 years)

20db@

R ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

L ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

R ear: _____ 6000HZ _____ 8000HZ

L ear: _____ 6000HZ _____ 8000HZ

Wears hearing aids? Yes No

Developmental Surveillance

Concerns about speech, learning, social and/or motor skills _____

Referrals:

Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498

Substance abuse - Help4WV.com/1-844-435-7498

Dental Vision Hearing

Other _____

Family Planning Program (FPP) **1-800-642-9704**

Children with Special HealthCare Needs (CSHCN)

1-800-642-9704

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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

Medical History

Initial Screen Periodic screen

Family health history reviewed _____

Currently receiving mental/behavioral health services? Yes No

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

Psychosocial/Behavioral

What is your living situation? _____

Family relationships Good Okay Poor

Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? Yes No _____

Are you still in school? Yes No Working? Yes No

What are your future plans? _____

What interests do you have outside of school and/or work? _____

*Tobacco use Cigarettes # per day _____

E-Cigarettes/Vaping *Chew Passive Smoke Risk

*Alcohol use _____

*Drug use (prescription or otherwise) _____

***If positive see Periodicity Schedule for links to CRAFFT and/or SBIRT screening tools**

Access to firearm(s)/weapon(s) Has a firearm(s)/weapon(s)

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

Witnessed violence/abuse Threatened with violence/abuse

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

Excessive television/video game/internet/cell phone use

Are you in a relationship? Yes (Male Female) No

Are you sexually active? Yes No

Method of contraception _____

Do you have children? Yes No _____

Traumatic Stress Reactions/PCL-C

***Positive screen = numbered responses 4 or greater**

Feelings over the past 2 weeks: (✓ Check one for each question)

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? Not at all (0) A little bit (1)

Moderately (2) Quite a bit (3) Extremely (4)

Feeling very upset when something reminded you of a stressful experience from the **past**? Not at all (0) A little bit (1)

Moderately (2) Quite a bit (3) Extremely (4)

Depression Screen/Patient Health Questionnaire (PHQ-2)

***Positive screen = numbered responses 3 or greater**

***If positive see Periodicity Schedule for link to PHQ-9**

Feelings over the past 2 weeks: (✓ Check one for each question)

Little interest or pleasure in doing things: Not at all (0)

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

Feeling down, depressed, or hopeless: Not at all (0)

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

Continue on page 2

School Entry Requirements



Name _____ DOB _____ Age _____ Sex: M F

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

- None Slight Moderate Severe

What kind of stress? (✓ Check those that apply)

- Relationships (partner, family and/or friends) School/work
 Drugs Alcohol Violence/abuse (physical, emotional and/or sexual)
 Family member incarcerated Lack of support/help
 Financial Emotional loss Health insurance
 Other _____

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

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

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

General Health

- Growth plotted on growth chart
 BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? Yes No

Fruits/vegetables/lean protein per day _____

- Vitamins _____
 Normal elimination _____
 Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? Yes No
Hours of sleep each night? _____

*Anemia Risk (Hemoglobin/Hematocrit)

- Low risk High risk

*Tuberculosis Risk

- Low risk High risk

*Dyslipidemia Risk

- Low risk High risk

Fasting lipoprotein required once between 17 and 20 years

*STI Risk

- Low risk High risk

*HIV Risk

- Low risk High risk

HIV test required once between 15 and 18 years

*See Periodicity Schedule for Risk Factors

Physical Examination (N=Normal, Abn=Abnormal)

- General Appearance N Abn _____
Skin N Abn _____
Neurological N Abn _____
Reflexes N Abn _____
Head N Abn _____
Neck N Abn _____
Eyes N Abn _____
Ears N Abn _____
Nose N Abn _____
Oral Cavity/Throat N Abn _____
Lung N Abn _____
Heart N Abn _____
Pulses N Abn _____
Abdomen N Abn _____
Genitalia N Abn _____
Back N Abn _____
Hips N Abn _____
Extremities N Abn _____

If female:

- LMP _____ Regular Irregular
Bleeding Normal Heavy
Cramping No Slight Severe

Possible Signs of Abuse/Neglect Yes No

Age Appropriate Health Education/Anticipatory

Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)

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

Plan of Care

Assessment

- Well Child Other Diagnosis

Labs

- Hemoglobin/hematocrit (if high risk)
 TB skin test (if high risk)
 Fasting lipoprotein (once between 17 and 20 years and/or high risk)
 STI test (if sexually active and/or high risk)
 HIV test (once between 15 and 18 years, if sexually active and/or 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 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