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

Name ________________________________________________________________  DOB____________________________  Age ____________________  Sex: □ M □ F

Weight __________________  Length ______________  Weight for Length ________  HC ________  Pulse ____________  BP (optional) _________  Resp __________  Temp __________  Pulse Ox (optional) ______________

Allergies □ NKDA _____________________________________________________

Current meds □ None_ □ Foster child __________________________________________ □ Parent □ Grandparent □ Foster parent □ Foster organization ____________________________  □ Kinship placement ____________________________  □ Foster organization ____________________________  □ Child with special health care needs ____________________________  □ Other _______________________________________

Accompanied by □ Parent □ Grandparent □ Foster parent □ Foster organization ____________________________  □ Foster organization ____________________________  □ Other _______________________________________

Medical History  
□ Initial screen □ Periodic screen □ Family health history reviewed

Parental history of postpartum depression □ Yes □ No ____________________________

In utero substance exposure □ Yes □ No ____________________________

Maternal Hep C exposure □ Yes □ No ____________________________

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitals: ________________________________________________

Psychosocial/Behavioral

What is your family’s living situation? __________________________________________

Family relationships □ Good □ Okay □ Poor □ Foster child □ Parent □ Grandparent □ Foster parent □ Foster organization ____________________________  □ Kinship placement ____________________________  □ Foster organization ____________________________  □ Other _______________________________________

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No ____________________________

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

Who do you contact for help and/or support? __________________________________________

Are you and/or your partner working outside home? □ Yes □ No ____________________________

Child care ____________________________________________________________

Child exposed to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise) ____________________________

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

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

□ None □ Slight □ Moderate □ Severe

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

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

Baby Pediatric Symptom Checklist (BPSC)  
*Positive screen = numbered responses 3 or greater in any of the 3 subscales. Further evaluation and/or investigation may be needed.

Subscale 1 (✓ Check one for each question) ____________________________

Does your child have a hard time being with people? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Does your child have a hard time in new places? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Does your child have a hard time with change? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Does your child mind being held by other people? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Subscale 1 score ____________________________

Subscale 2 (✓ Check one for each question) ____________________________

Does your child cry a lot? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Does your child have a hard time calming down? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Is your child fussy or irritable? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Is it hard to comfort your child? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Subscale 2 score ____________________________

Subscale 3 (✓ Check one for each question) ____________________________

Is it hard to keep your child on a schedule or routine? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Is it hard to put your child to sleep? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Is it hard to get enough sleep because of your child? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Does your child have trouble staying asleep? □ Not at all (0) □ Somewhat (1) □ Very much (2) ____________________________

Subscale 3 score ____________________________

Developmental

Developmental Surveillance (✓ Check those that apply) ____________________________

Social Language and Self-help □ *Child can prodeclarative point (point to comment on an interesting object/event-will look alternatively between object/event and parent) □ Child can point to ask for something to get help □ Child can look around when you say things like “Where’s your ball?” or “Where’s your blanket?” □ Child can imitate scribbling □ Child can drink from a cup with little spilling

Verbal Language (Expressive and Receptive) □ Child can use 3 words other than names □ Child can speak in sounds like an unknown language □ Child can follow directions that do not include a gesture

Gross Motor □ Child can squat to pick up objects □ Child can crawl up a few steps □ Child can run

Fine Motor □ Child can make marks with a crayon □ Child can drop an object in and take object out of a container

*Absence of these milestones = Autism Screen

Concerns and/or questions ____________________________

General Health

□ Growth plotted on growth chart ____________________________

Do you think your child sees okay? □ Yes □ No ____________________________

Do you think your child hears okay? □ Yes □ No ____________________________

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### Oral Health
- **Date of last dental visit:**
- **Current oral health problems:**
- **Water source:**
  - Public
  - Well
  - Tested
- **Fluoride supplementation:**
  - Yes
  - No
- **Fluoride varnish applied (apply every 3 to 6 months):**
  - Yes
  - No

### Nutrition/Sleep
- **Breastfeeding - Frequency:**
- **Bottle feeding - Amount:**
- **Formula:**
- **Milk**
- **Juice**
- **Water**
- **Normal eating habits**
- **Vitamins**
- **Normal elimination:**
- **Normal sleeping patterns:**

#### *Anemia Risk (Hemoglobin/Hematocrit)*
- **Low risk**
- **High risk**

#### *Lead Risk*
- **Low risk**
- **High risk**

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

### Physical Examination
- **General Appearance**
  - N
  - Abn
- **Skin**
  - N
  - Abn
- **Neurological**
  - N
  - Abn
- **Reflexes**
  - N
  - Abn
- **Head**
  - N
  - Abn
- **Neck**
  - N
  - Abn
- **Eyes**
  - N
  - Abn
- **Red Reflex**
  - N
  - Abn
- **Ocular Alignment**
  - N
  - Abn
- **Ears**
  - N
  - Abn
- **Nose**
  - N
  - Abn
- **Oral Cavity/Throat**
  - N
  - Abn
- **Lung**
  - N
  - Abn
- **Heart**
  - N
  - Abn
- **Pulses**
  - N
  - Abn
- **Abdomen**
  - N
  - Abn
- **Genitalia**
  - N
  - Abn
- **Back**
  - N
  - Abn

### Signs of Abuse/Neglect
- **Yes**
- **No**

### Age Appropriate Health Education/Anticipatory Guidance
*Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org*
- **Communication and Social Development, Sleep Routines and Issues, Temperament, Development, Behavior, and Discipline, Healthy Teeth, and Safety**
- **Discussed**
- **Handouts Given**

### Questions/Concerns/Notes

### Plan of Care

#### Assessment
- **Well Child**
- **Other Diagnosis**

#### Immunizations
- **UTD**
  - Given, see immunization record
  - Entered into WVSII S

#### Labs
- **Blood lead**
  - (if high risk)
  - (enter into WVSII S)
- **Hemoglobin/hematocrit**
  - (if high risk)

#### Referrals
- **Developmental**
- **Dental**
- **Other**

#### Medical Necessity
- **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**

### Follow Up/Next Visit
- **18 months of age**
- **Other**

### Screen has been reviewed and is complete

### Please Print Name of Facility or Clinician

### Signature of Clinician/Title