Screen Date_____

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

18 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 _____ ☐ Child with special health care needs_____

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

Medical History

☐ Initial screen ☐ Periodic screen

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

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

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

_____

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

_____

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

_____

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

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

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_____

_____

_____

_____

Developmental

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

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

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

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Concerns and/or questions_____

_____

_____

General Health

☐ Growth plotted on growth chart

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

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

Oral Health

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

☐ Breast feeding; Frequency _____

☐ Bottle feeding; Amount_____ Frequency_____

☐ Formula _____

Plans for weaning_____

☐ Milk ☐ Juice ☐ Water

☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

☐ Low risk ☐ High risk

***Lead Risk**

☐ Low risk ☐ High risk

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

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

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

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

Temperament, Development, Toilet Training, Behavior and Discipline

- ☐ Anticipation of return to separation anxiety and managing behavior with consistent limits
- ☐ Recognizing signs of toilet training and readiness and parental expectations
- ☐ New sibling planned or on the way

Communication and Social Development

- ☐ Encouragement of language, use of simple words and phrases, encouragement in reading, playing, talking, and singing

Television Viewing and Digital Media

- ☐ Promotion of reading, physical activity and safe play

Healthy Nutrition

- ☐ Nutritious foods
- ☐ Water, milk, juice
- ☐ Expressing independence through food likes and dislikes

Safety

- ☐ Car safety seats and parental use of seat belts
- ☐ Sun protection
- ☐ Firearm safety
- ☐ Safe home environment: burns, fires, and falls

☐ **Other**

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations

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

Labs

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

Referrals

☐ Developmental ☐ Dental
☐ Other _____

☐ Birth to Three (BTT) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 24 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title