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

24 Month Form

Screen Date __________________________

Name ________________________________ DOB ____________________ Age ____________ Sex: □ M □ F

Weight ______ Height ______ BMI _______ HC _______ Pulse _______ BP (optional) _______ Resp _______ Temp _______ Pulse Ox (optional) _______

Allergies □ NKDA __________________________

Current meds □ None __________________________

□ Foster child ___________________________ □ Kinship placement ___________________________ □ Child with special health care needs __________________________

Accompanied by □ Parent □ Grandparent □ Foster parent □ Foster organization ___________________________ □ Other ___________________________

Medical History
□ Initial screen □ Periodic screen

□ Family health history reviewed __________________________

Parental history of postpartum depression □ Yes □ No __________________________

In utero substance exposure □ Yes □ No __________________________

Child currently receiving mental/behavioral health services? □ Yes □ No __________________________

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

Psychosocial/Behavioral

What is your family’s living situation? __________________________

Family relationships □ Good □ Okay □ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? □ Yes □ No __________________________

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

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

Child care __________________________
Child has ability to separate from parents/caregivers □ Yes □ No __________________________

Child exposed to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise) □ Access to firearm(s)/weapon(s)

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

Witnessed violence/abuse □ Threatened with violence/abuse □ Scary experience that your child cannot forget __________________________

Do you utilize a car seat for your child? □ Yes □ No __________________________

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

How much stress are you and your family under now? □ None □ Slight □ Moderate □ Severe

What kind of stress? (✓ Check those that apply)
□ Relationships (partner, family and/or friends) □ School/work

□ Child care □ Drugs □ Alcohol □ Violence/abuse (physical, emotional and/or sexual) □ Family member incarcerated □ Lack of support/help □ Financial/money □ Emotional loss □ Health insurance □ Other __________________________

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

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

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

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

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

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

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

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

Developmental Surveillance (✓ Check those that apply)
□ Child can play alongside other children, also called parallel play

□ Child can take off some clothing □ Child can scoop well with a spoon □ Child can use 50 words □ Child can combine 2 words into short phrase or sentence □ Child can follow 2-step command

□ Child can name at least 5 body parts, such as nose and hand □ Child’s speech is 50% understandable to strangers □ Child can kick a ball □ Child can jump off the ground with 2 feet □ Child can run with coordination □ Child can climb up a ladder at a playground □ Child can stack objects □ Child can turn book pages □ Child can use his/her hands to turn objects like knobs, toys, and lids □ Child can draw a line __________________________

Autism screening completed with an Autism Specific Tool
□ M-CHAT-R/F □ Other tool __________________________

Results in child’s record □ Yes □ No __________________________

General Health

□ Growth plotted on growth chart

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

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

Oral Health

Date of last dental visit __________________________

Current oral health problems __________________________

Water source □ Public □ Well □ Tested

Fluoride supplementation □ Yes □ No __________________________

Fluoride varnish applied (apply every 3 to 6 months) □ Yes □ No __________________________

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Physiohgy

Nutrition/Sleep
- Normal eating habits
- Fruits/vegetables/lean protein per day
- Vitamins
- Normal elimination
- Toilet trained: Yes, No
- Normal sleeping patterns
- Hours of sleep each night

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

*Lead Risk
- Blood lead required at 24 months

*Tuberculosis Risk
- Low risk
- High risk

*Dyslipidemia Risk
- Low risk
- High risk

*See Periodicity Schedule for Risk Factors


days

Physical Examination (N=Normal, Abn=Abnormal)

<table>
<thead>
<tr>
<th>General Appearance</th>
<th>N</th>
<th>Abn</th>
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<tbody>
<tr>
<td>Skin</td>
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<td>Abn</td>
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<tr>
<td>Neurological</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Reflexes</td>
<td>N</td>
<td>Abn</td>
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<tr>
<td>Head</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Neck</td>
<td>N</td>
<td>Abn</td>
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<td>N</td>
<td>Abn</td>
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<tr>
<td>Red Reflex</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Ocular Alignment</td>
<td>N</td>
<td>Abn</td>
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<tr>
<td>Ears</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Nose</td>
<td>N</td>
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<tr>
<td>Oral Cavity/Throat</td>
<td>N</td>
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</tr>
<tr>
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<tr>
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</tr>
<tr>
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<tr>
<td>Hips</td>
<td>N</td>
<td>Abn</td>
</tr>
<tr>
<td>Extremities</td>
<td>N</td>
<td>Abn</td>
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</tbody>
</table>

Signs of Abuse/Neglect
- Yes
- No

Age Appropriate Health Education/Anticipatory Guidance

- Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org
- Social Determinants of Health, Temperament and Behavior, Assessment of Language Development, Toilet Training, and Safety
- Discussed
- Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
- Well Child
- Other Diagnosis

Immunizations
- UTD
- Given, see immunization record
- Entered into WVSIIS

Labs
- Hemoglobin/hematocrit (if high risk)
- Blood lead (required at 24 months) (enter into WVSIIS)
- TB skin test (if high risk)
- Lipid profile (if high risk)
- Other

Referrals
- Developmental
- Dental
- Blood lead ≥5ug/dl
- Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
- Other

Medical Necessity

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

Follow Up/Next Visit
- 30 months of age

Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title

VWDHHR/BPH/OMCFH/HC 11-2021