Screen Date_____________________________________________________
Who do you contact for help and/or support?____________________
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)?
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization ☐ Other __________________________
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:________________________________________
In utero substance exposure ☐ Yes ☐ No __________________________
Maternal Hep C exposure ☐ Yes ☐ No __________________________
Newborn metabolic screen ☐ NL ☐ Results in child’s record __________________________
Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest________________________
Results in child’s record __________________________
Medical History
☐ Initial screen ☐ Periodic screen __________________________
☐ Family health history reviewed __________________________
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________________________
Results in child’s record __________________________
Psychosocial/Behavioral
What is your family’s living situation?________________________
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 plans? __________________________
Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise) __________________________
How much stress are you and your family under now? ☐ None ☐ Slight ☐ Moderate ☐ Sever
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 __________________________
Maternal Depression/Patient Health Questionnaire (PHQ-2)
*Positive screen = numbered responses 3 or greater
*If positive, see Periodicity Schedule for link to Edinburgh Postnatal Depression Scale (EPDS)
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)
Subscale 2 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 smiles responsively
☐ Child makes sounds that let you know if he/she is happy
Verbal Language (Expressive and Receptive) ☐ Child makes short cooing sounds
Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position
Fine Motor ☐ Child can open and shut hands ☐ Child can briefly bring hands together __________________________
Continue on page 2
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
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency
☐ Bottle feeding - Amount__________ Frequency__________
☐ Formula
☐ Normal elimination
☐ Normal sleeping patterns
☐ Place on back to sleep
☐ Sleeps 3 to 4 hours at a time
Concerns and/or questions______________________________________________

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
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/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care
Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIS

Labs_______________________________________________________
_______________________________________________________
_______________________________________________________

Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
☐ Developmental
☐ Other

☐ 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
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 months of age
☐ Other_______________________________________________________

☐ Screen has been reviewed and is complete

Please Print Name of Facility or Clinician
_______________________________________________________

Signature of Clinician/Title
_______________________________________________________