

Screen Date _____

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

4 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 _____ 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 _____

In utero substance exposure Yes No _____

Maternal Hep C exposure Yes No _____

High birth score Yes No _____

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

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 _____

Child has ability to separate from parents/caregivers Yes No

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 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 _____

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)

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 laugh out loud

Child can look for you or another caregiver when upset

Verbal Language (Expressive and Receptive) Child can turn to voices Child can make extended cooing sounds

Gross Motor Child can support himself/herself on elbows and wrists when on stomach Child can roll over from stomach to back

Fine Motor Child can keep his/her hands unfisted Child can play with fingers in midline Child can grasp objects

Continue on page 2

Name _____ DOB _____ Age _____ Sex: M F

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 _____
- Juice Water
- Has started solid foods Normal eating habits
- Vitamins _____
- Normal elimination _____
- Normal sleeping patterns _____
- Place on back to sleep _____

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

- Low risk High risk

***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 _____
- 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>*)
 Social Determinants of Health, Infant Behavior and Development, Oral Health, Nutrition and Feeding, 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*)
- Other _____

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 dhr.wv.gov/healthcheck.

Follow Up/Next Visit 6 months of age

- Other _____

Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title