

Screen Date _____

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

6 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 _____

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 Several days(1) More than ½ the days(2)

Nearly every day(3)

Feeling down, depressed, or hopeless

Not at all Several days(1) More than ½ the days(2)

Nearly every day(3)

Concerns and/or questions _____

Developmental

Developmental Surveillance (✓ Check those that apply)

Social Language and Self-help Child can pat or smile at his/her reflection Child can look when you call his/her name

Verbal Language (Expressive and Receptive) Child can babble

Child can make sounds like "ga", "ma", or "ba"

Gross Motor Child can roll over from back to stomach Child can sit briefly without support

Fine Motor Child can pass a toy from one hand to another

Child can rake small objects with 4 fingers Child can bang small objects on surface

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

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

Tooth eruption Yes No

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 _____

Juice Water

Has started solid foods Normal eating habits

Vitamins _____

Normal elimination _____

Normal sleeping patterns _____

Place on back to sleep _____

Concerns and/or questions _____

Continue on page 2

Name _____ DOB _____ Age _____ Sex: M F

***See Periodicity Schedule for Risk Factors**

***Lead Risk**

- Low risk High risk

***Tuberculosis Risk**

- Low risk High risk

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 Yes No

Concerns and/or questions _____

Anticipatory Guidance

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

Social Determinants of Health

- Living situation and food security
- Tobacco, alcohol, and drugs
- Parental depression
- Family relationships and support
- Child care

Infant Behavior and Development

- Parents as teachers
- Community and early literacy
- Media
- Emerging infant independence
- Putting self to sleep
- Self-calming

Oral Health

- Fluoride, oral hygiene/soft toothbrush, avoidance of bottle in bed

Nutrition and Feeding

- General guidance on feeding
- Solid foods
- Pesticides in vegetables and fruits
- Fluids and juice
- Breastfeeding guidance
- Formula-feeding guidance

Safety

- Car safety seats
- Safe sleep
- Safe home environment (burns, sun exposure, choking, poisoning, drowning, falls)

Other

Plan of Care

Assessment Well Child Other Diagnosis

Immunizations

- UTD Given, see immunization record Entered into WVSIIS

Labs

- Blood lead (if high risk) (enter into WVSIIS)
- TB skin test (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

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 9 months of age

- Other _____

Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title