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 _____☐ 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?_____

_____

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

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

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 <u>any</u> 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 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

_____

_____

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

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

☐ 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_____

***Lead Risk**

☐ Low risk ☐ High risk

***Tuberculosis Risk**

☐ 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

_____

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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

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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**

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 ☐ 9 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title