Screen Date_____

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

9 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** _____

_____

Parental history of postpartum depression ☐ Yes ☐ No

_____

In utero substance exposure ☐ Yes ☐ No _____

Maternal Hep C exposure ☐ Yes ☐ No _____

High birth score ☐ 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 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_____

_____

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 and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

Concerns and/or questions_____

_____

_____

_____

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 _____

Continue on page 2

Name______________________________ DOB__________________ Age__________ Sex: ☐ M ☐ F

Nutrition/Sleep

☐ Breastfeeding - Frequency ________________________
☐ Bottle feeding - Amount____________Frequency_________
☐ Formula ______________________________
☐ Juice ☐ Water
☐ Has started solid foods ☐ Table foods ☐ Normal eating habits
☐ Vitamins
☐ Normal elimination_______________________
☐ Normal sleeping patterns_______________________
☐ Place on back to sleep_______________________

***Lead 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

____
____
____
____

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, Discipline, 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
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Other
____
____

Referrals
☐ 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 ☐ 12 months of age

☐ Other______________________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

____
Signature of Clinician/Title