EPSDT/HealthCheck Health History Form 0-6 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to Child:** _____

Child's Health History

Pregnancy and Birth

Medical problems during pregnancy? _____

_____

In utero substance exposure? _____

Maternal Hep C exposure? _____

Where was the child born? _____

Delivered by: ☐ Vaginal ☐ C-section

Why C-section? _____

Birth Weight: _____ Birth Length: _____

High Birth Score: _____

☐ Full Term (≥ 37 weeks gestation)

☐ Preterm (≤ 36 weeks gestation)

☐ NICU stay: _____ weeks

Other problems in the newborn period? _____

Infancy and Childhood

Has your child ever been treated for or diagnosed with:

☐ Asthma or wheezing _____

☐ Pneumonia _____

☐ Lung problems _____

☐ Heart murmur _____

☐ Anemia _____

☐ Recurrent ear infections _____

☐ Hearing problems _____

☐ Vision or eye problems _____

☐ Urinary tract infections _____

☐ Stomach or digestive problems _____

☐ Seasonal allergies or eczema _____

☐ Seizures _____

☐ Broken bone(s) _____

☐ Learning disability _____

_____

☐ Depression/anxiety _____

☐ ADD/ADHD_____

☐ Other chronic medical problems _____

_____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including mental/behavioral health providers, your child is currently seeing and reason: _____

_____

Developmental

Do you have concerns about any of the following:

☐ Problems with sleeping or nightmares

☐ The way your child uses his/her arms, fingers or legs

☐ Speech problems

☐ Bad temper/breath holding/jealousy

☐ Nail biting/thumb sucking

☐ Vision (Are you concerned about your child's vision?)

☐ Hearing (Are you concerned about your child's hearing?)

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke/use tobacco products/e-cigarettes/ vaping? ☐ Yes ☐ No

TV hours per day _____

Internet/video games hours per day _____

Cell phone use hours per day _____

Is violence at home a concern? ☐ Yes ☐ No

Child's Health History

Medications

Current medications and dose: _____

_____

_____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

_____

_____

Nutrition and Feeding

☐ Has your child had any feeding/dietary problems? _____

_____

☐ Unexplained weight gain

☐ Unexplained weight loss

☐ Food allergies: _____

☐ Participates in WIC ☐ Yes ☐ No

Dental

☐ Problems with teeth or gums

☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Water source: ☐ City ☐ Well

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Postpartum depression	☐			☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed mental condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐

Other: _____

_____

Other Concerns:_____

_____

_____

Reviewed by: _____

Date: _____

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
West Virginia HealthCheck Program

EPSDT/HealthCheck Health History Form 7-20 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to Child:** _____

Child's Health History

Childhood

Has your child ever been treated for or diagnosed with:

☐ Asthma or wheezing _____
☐ Pneumonia _____
☐ Lung problems _____
☐ Heart murmur _____
☐ Anemia _____
☐ Recurrent ear infections _____
☐ Hearing problems _____
☐ Vision or eye problems _____
☐ Urinary tract infections _____
☐ Stomach or digestive problems _____
☐ Seasonal allergies or eczema _____
☐ Seizures _____
☐ Broken bone(s) _____
☐ Learning disability _____
_____
☐ Depression/anxiety _____
☐ ADD/ADHD _____
☐ Other chronic medical problems: _____
_____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including mental/behavioral health providers, your child is currently seeing and reason: _____
_____
_____

Developmental/Behavior

Do you have concerns about any of the following:

☐ Problems with sleeping or nightmares
☐ The way your child uses his/her arms, fingers or legs
☐ Speech problems
☐ Bad temper/breath holding/jealousy
☐ Nail biting/thumb sucking
☐ Bedwetting (after 6 years)
☐ Vision (Are you concerned about your child's vision?)
☐ Hearing (Are you concerned about your child's hearing?)

Does your child have problems with:

☐ School attendance
☐ Getting along with other children including siblings
☐ Getting along with parents or other adults
☐ Threaten to harm self, others or animals
☐ Sexual acting out
☐ Destroying property
☐ Drug use, alcohol use, smoking, e-cigarettes and/or vaping

Puberty

Concerns about:

☐ Body changes
☐ Sexual activity
☐ Sexually transmitted infection
☐ Discharge: vaginal or penis
☐ Contraception

For Girls:

Age of first menstrual period? _____

Child's Health History

Medications

Current medications and dose: _____
_____
_____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____
_____
_____

Nutrition

☐ Has your child had any dietary problems? _____
_____
☐ Unexplained weight gain
☐ Unexplained weight loss
☐ Food allergies: _____

Dental

☐ Problems with teeth or gums
☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke/use tobacco products/e-cigarettes/ vaping? ☐ Yes ☐ No

TV hours per day _____

Internet/video games hours per day _____

Cell phone/social media hours per day _____

Is violence at home a concern? ☐ Yes ☐ No

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed Mental Condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐

Other _____

Other Concerns:_____
_____

Reviewed by: _____

Date: _____

Screen Date_____

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

Newborn to 1 Week 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

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

In utero substance exposure ☐ Yes ☐ No _____
Maternal Hep C exposure ☐ Yes ☐ No _____
Gestational age_____ Maternal labs_____
Complications_____
Birth history ☐ NSVD ☐ C-section Breech ☐ Yes ☐ No
Birth weight_____ Discharge weight_____
High birth score ☐ Yes ☐ No _____
Newborn metabolic screen ☐ NL
Newborn bilirubin screen ☐ NL
Newborn critical congenital heart disease pulse oximetry _____
Newborn hearing screen ☐ Pass ☐ Fail ☐ Pending ☐ Retest

_____

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 ☐ 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_____

_____

Does your child mind being held by other people?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child cry a lot?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much
Is your child fussy or irritable?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to comfort your child?
☐ Not at all ☐ Somewhat ☐ Very Much
Is it hard to put your child to sleep?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to get enough sleep because of your child?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have trouble staying asleep?
☐ Not at all ☐ Somewhat ☐ Very much

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child has periods of wakefulness ☐ Child looks at and studies you when awake ☐ Child looks in your eyes when being held ☐ Child calms when picked up ☐ Child responds differently to soothing touch and alerting touch
Verbal Language ☐ Child communicates discomfort through crying, facial expressions and body movements ☐ Child moves or calms to your voice
Gross Motor ☐ Child moves in response to visual or auditory stimuli ☐ Child moves arms and legs symmetrically and reflexively when startled ☐ Child lifts head briefly when on stomach and can turn it to the side
Fine Motor ☐ Child keeps hands in fist ☐ Child automatically grasps others' fingers or objects

_____
_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Oral Health

Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep

☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Place on back to sleep_____

_____
_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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	_____
Ears	☐ N ☐ Abn	_____
Nose	☐ N ☐ Abn	_____
Oral Cavity/Throat	☐ N ☐ Abn	_____
Lung	☐ N ☐ Abn	_____
Heart	☐ N ☐ Abn	_____
Pulses	☐ N ☐ Abn	_____
Abdomen	☐ N ☐ Abn	_____
Umbilical cord	☐ N ☐ Abn	_____
Genitalia	☐ N ☐ Abn	_____
Back	☐ N ☐ Abn	_____
Hips	☐ N ☐ Abn	_____
Extremities	☐ N ☐ Abn	_____

Jaundice ☐ Yes ☐ No

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Concerns and/or questions _____

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

Social Determinants of Health, Parental/Family Health and Well-Being, Newborn Behavior and Care, 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_____

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 ☐ 1 month of age ☐ 2 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____

Please Print Name of Facility or Clinician

_____

Signature of Clinician/Title

Screen Date_____

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

By 1 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 _____

Birth weight_____ Discharge weight_____

High birth score ☐ Yes ☐ No _____

Newborn metabolic screen ☐ NL ☐ Results in child's record

Newborn bilirubin screen ☐ NL ☐ Results in child's record

Newborn critical congenital heart disease pulse oximetry _____

☐ Results in child's record

Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____

☐ Results in child's record

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

_____

Psychosocial/Behavioral

What is your family's living situation?_____

_____

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)_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ 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 (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 looks at you and follows you with his/her eyes ☐ Child has self-comforting behaviors, such as bringing hands to mouth ☐ Child becomes fussy when bored ☐ Child calms when picked up or spoken to

Verbal Language (Expressive and Receptive) ☐ Child makes brief short vowel sounds ☐ Child alerts to unexpected sounds ☐ Child quiets and turns to your voice ☐ Child shows signs of sensitivity to environment (excessive crying, tremors, excessive startles) ☐ Child has different types of cries for hunger and tiredness

Gross Motor ☐ Child moves both arms and legs together ☐ Child can hold chin up when on stomach

Fine Motor ☐ Child can open fingers slightly when at rest

_____

_____

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 _____
☐ Normal elimination_____
☐ Normal sleeping patterns_____
☐ Place on back to sleep_____
☐ Sleeps 3 to 4 hours at a time_____
☐ Can stay awake for 1 hour or longer_____

***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	_____
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, Parental/Family Health and Well-Being, Infant Behavior and Development, 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
☐ 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 ☐ 2 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

2 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 _____

Newborn metabolic screen ☐ NL ☐ Results in child's record

Newborn hearing screen ☐ Pass ☐ Fail ☐ Retest_____

☐ Results in child's record

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 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)

_____

_____

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 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

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 _____
☐ 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)*

Social Determinants of Health, Parental/Family Health and Well-Being, Infant Behavior and Development, 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_____
_____
_____
_____

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

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 dhhr.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

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

_____

_____

_____

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

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

____
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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, 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

Screen Date_____

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

12 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 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

Concerns and/or questions_____

_____

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 (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can protoimperative point (point to request an object) ☐ Child can imitate new gestures ☐ Child can look for hidden objects

Verbal Language (Expressive and Receptive) ☐ *Child can babble ☐ *Child can imitate vocalizations and sounds ☐ Child can use "Dada" or "Mama" specifically ☐ Child can use 1 word other than "Mama," "Dada," or personal name

Gross Motor ☐ Child can take first independent steps ☐ Child can stand without support

Fine Motor ☐ Child can drop an object in a cup ☐ Child can pick up small objects with 2 finger pincer grasp ☐ Child can pick up food and eat it

Absence of these milestones = Autism Screen

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

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Oral Health
Dental referral required at 12 months
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 _____
Plans for weaning_____
☐ Milk ☐ Juice ☐ Water
☐ Has started solid foods ☐ Table foods ☐ Normal eating habits
☐ Vitamins
☐ Normal elimination_____
☐ Normal sleeping patterns_____

***Anemia Risk (Hemoglobin/Hematocrit)**
Hemoglobin/hematocrit required at 12 months

***Lead Risk**
Blood lead required at 12 months

***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

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

Social Determinants of Health, Establishing Routines, Feeding and Appetite Changes, Establishing a Dental Home, 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
☐ **Hemoglobin/hematocrit** *(required at 12 months)*
☐ **Blood lead** *(required at 12 months) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Other
_____
_____

Referrals
☐ Developmental ☐ **Dental** ☐ Blood lead ≥5ug/dl
☐ Other _____
_____

☐ 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 ☐ 15 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

15 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 _____

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 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 (✓*Check those that apply)*

Social Language and Self–help ☐ *Child can prodeclarative point (point to comment on an interesting object/event-will look alternatively between object/event and parent) ☐ Child can point to ask for something to get help ☐ Child can look around when you say things like "Where's your ball?" or "Where's your blanket?" ☐ Child can imitate scribbling ☐ Child can drink from a cup with little spilling

Verbal Language (Expressive and Receptive) ☐ Child can use 3 words other than names ☐ Child can speak in sounds like an unknown language ☐ Child can follow directions that do not include a gesture

Gross Motor ☐ Child can squat to pick up objects ☐ Child can crawl up a few steps ☐ Child can run

Fine Motor ☐ Child can make marks with a crayon ☐ Child can drop an object in and take object out of a container

Absence of these milestones = Autism Screen

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

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Oral Health
Date of last dental visit_____
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 _____
Plans for weaning_____
☐ Milk ☐ Juice ☐ Water
☐ Normal eating habits
☐ Vitamins
☐ Normal elimination_____
☐ Normal sleeping patterns_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***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	_____
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)*

Communication and Social Development, Sleep Routines and Issues, Temperament, Development, Behavior, and Discipline, Healthy Teeth, 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
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Other _____
_____

Referrals
☐ Developmental ☐ Dental
☐ Other _____
_____

☐ 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 ☐ 18 months of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

18 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 _____

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 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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

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_____

_____

Does your child seem nervous or afraid?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?

☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?

☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

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

Date of last dental visit_____

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 _____

Plans for weaning_____

☐ Milk ☐ Juice ☐ Water

☐ Normal eating habits

☐ Vitamins

☐ Normal elimination_____

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***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	_____
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)*

Temperament, Development, Toilet Training, Behavior and Discipline, Communication and Social Development, Television Viewing and Digital Media, Healthy Nutrition, 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)*
☐ Blood lead *(if high risk) (enter into WVSIIS)*
☐ Other _____

Referrals
☐ Developmental ☐ Dental
☐ Other _____

☐ 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 ☐ 24 months of age
☐ Other_____

☐ **Screen has been reviewed and is complete**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

24 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height _____ BMI_____ 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 _____

Child currently receiving mental/behavioral health services?
☐ 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 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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Do you utilize a car seat for your child? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

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_____

_____

Does your child seem nervous or afraid?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?
☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?
☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?
☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to know what your child needs?
☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

Developmental

Developmental Surveillance (✓*Check those that apply)*

☐ Child can play alongside other children, also called parallel play ☐ Child can take off some clothing ☐ Child can scoop well with a spoon ☐ Child can use 50 words ☐ Child can combine 2 words into short phrase or sentence ☐ Child can follow 2-step command ☐ Child can name at least 5 body parts, such as nose and hand ☐ Child's speech is 50% understandable to strangers ☐ Child can kick a ball ☐ Child can jump off the ground with 2 feet ☐ Child can run with coordination ☐ Child can climb up a ladder at a playground ☐ Child can stack objects ☐ Child can turn book pages ☐ Child can use his/her hands to turn objects like knobs, toys, and lids ☐ Child can draw a line

_____

_____

_____

☐ **Autism screening completed with an Autism Specific Tool**

☐ M-CHAT-R/F ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

_____

_____

_____

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

Date of last dental visit_____

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
☐ Normal eating habits
Fruits/vegetables/lean protein per day____________________
☐ Vitamins
☐ Normal elimination____________________
Toilet trained ☐ Yes ☐ No
☐ Normal sleeping patterns____________________
Hours of sleep each night?____________________

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
Blood lead required at 24 months

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia 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	________
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, Temperament and Behavior, Assessment of Language Development, Toilet Training, 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)*
☐ **Blood lead** *(required at 24 months) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other ____________________

Referrals
☐ Developmental ☐ Dental ☐ Blood lead ≥5ug/dl
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Other ____________________

☐ 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 ☐ 30 months of age

☐ Other____________________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

____
Signature of Clinician/Title

Screen Date_____

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

30 Month Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ 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 _____

Child currently receiving mental/behavioral health services?

☐ Yes ☐ No _____

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

_____

_____

Psychosocial/Behavioral

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

☐ Scary experience that your child cannot forget_____

_____

Do you utilize a car seat for your child? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

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_____

_____

_____

Does your child seem nervous or afraid?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child seem sad or unhappy?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child get upset when things are not done a certain way?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time with change?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have trouble playing with other children?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child break things on purpose?

☐ Not at all ☐ Somewhat ☐ Very much

Does your child have a hard time calming down?

☐ Not at all ☐ Somewhat ☐ Very much

Is your child aggressive?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to take your child out in public?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to know what your child needs?

☐ Not at all ☐ Somewhat ☐ Very much

Is it hard to get your child to obey you?

☐ Not at all ☐ Somewhat ☐ Very much

_____

_____

_____

Developmental

☐ **Developmental surveillance and screening completed with Standardized Screening Tool**

☐ ASQ3 ☐ Other tool_____

Results in child's record ☐ Yes ☐ No

_____

_____

_____

_____

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

Date of last dental visit_____

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

☐ Normal eating habits

Fruits/vegetables/lean protein per day_____

☐ Vitamins _____

☐ Normal elimination_____

Toilet trained ☐ Yes ☐ No

☐ Normal sleeping patterns_____

Hours of sleep each night?_____

_____

_____

_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***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	_____
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, Temperament and Behavior, Assessment of Language Development, Toilet Training, 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)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Other _____

Referrals
☐ Developmental ☐ Dental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Other _____

☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Women, Infants and Children (WIC) **1-304-558-0030**
☐ Birth to Three (BTT) transition planning

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 ☐ 3 years of age

☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

3 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement _____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen *(Subjective screen required)*
Do you think your child hears okay? ☐ Yes ☐ No
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and urinate by himself/herself ☐ Child can put on coat, jacket or shirt by themselves ☐ Child can eat independently ☐ Child can engage in imaginative play ☐ Child can play in cooperation and share ☐ Child can use 3 word sentences ☐ Child can speak in words that are 75% understandable to strangers ☐ Child can tell you a story from a book or TV ☐ Child can compare things using words like bigger or shorter ☐ Child can understand simple prepositions, such as on or under ☐ Child can pedal a tricycle ☐ Child can climb on and off couch or chair ☐ Child can jump forward ☐ Child can draw a single circle ☐ Child can draw a person with head and 1 other body part ☐ Child can cut with child scissors

☐ Concerns about child's speech, learning, or motor skills
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704
☐ Women, Infants and Children (WIC) **1-304-558-0030**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care/after school care _____
Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____

Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

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_____
_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- ☐ Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***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	_____
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	_____

Possible Signs of Abuse/Neglect ☐ Yes ☐ No
Concerns and/or questions_____
_____
_____
_____

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

Social Determinants of Health, Playing with Siblings and Peers, Encouraging Literacy Activities, Promoting Healthy Nutrition and Physical Activity, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Other
_____
_____

Referrals
See page 1, school requirements

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 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

4 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement _____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@ ☐ UTO *(retest in 6 months)*
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and have a bowel movement by himself/ herself ☐ Child can brush his/her teeth ☐ Child can dress and undress without much help ☐ Child can engage in well-developed imaginative play ☐ Child can answer simple questions ☐ Child can speak in words that are 100% understandable to strangers ☐ Child can draw pictures that you recognize ☐ Child can follow simple rules when playing games ☐ Child can tell you a story from a book ☐ Child can skip on 1 foot ☐ Child can climb stairs, alternating feet, without support ☐ Child can draw a person with at least 3 body parts ☐ Child can draw a simple cross ☐ Child can unbutton and button medium sized buttons ☐ Child can grasp pencil with thumb and fingers instead of fist
☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704
☐ Women, Infants and Children (WIC) **1-304-558-0030**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care/after school care _____
_____

Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____

Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

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_____
_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ Has been sexually inappropriate such that adults have concern about welfare of other children who may be around the child unsupervised
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to control or deflect)
- ☐ Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia 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	_____
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	_____

Possible 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, School Readiness, Developing Healthy Nutrition and Personal Habits, Media Use, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other _____

_____

Referrals
See page 1, school requirements

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 ☐ 5 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

5 and 6 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(5 years, apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can balance on one foot, hops and skips
☐ Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles
☐ Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors
☐ Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance

☐ Concerns about child's speech, learning, or motor skills
_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____
_____

In utero substance exposure ☐ Yes ☐ No
Child currently receiving mental/behavioral health services?
☐ Yes ☐ No _____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No
Child care/after school care _____
_____
Child's grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____

Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

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_____
_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Does not achieve satisfactorily due to poor attention or high activity level; special accommodations are needed or implemented
- ☐ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits)
- ☐ On more than one occasion, committed acts that would be considered delinquent if a child were older (e.g., vandalism, defacing property, threatening aggression, shoplifting other than minor items such as candy)
- ☐ Repeatedly and intentionally plays with fire such that damage to property or person could result
- ☐ Often mean and nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play, would rather be alone
- ☐ Extremely tense or fearful (e.g., overreacts to sounds and noises)
- ☐ Persistent self-criticism or feelings of worthlessness
- ☐ Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, cuts self)
- ☐ Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)
- ☐ Extremely limited in expressing self verbally and this is not due to any know physical or sensory disability, speech impediment or lack of familiarity with English
- ☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources

_____
_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

*Anemia Risk (Hemoglobin/Hematocrit)
☐ Low risk ☐ High risk

*Lead Risk
☐ Low risk ☐ High risk

*Tuberculosis Risk
☐ Low risk ☐ High risk

*Dyslipidemia Risk *(year 6)*
☐ 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	_____
Neck	☐ N ☐ Abn	_____
Eyes	☐ 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	_____

Possible 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, Developmental and Mental Health, School, Physical Growth and Development and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(year 6, if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

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 ☐ 6 years of age ☐ 7 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

7 and 8 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about child's speech, learning, or motor skills
_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
☐ **Family health history reviewed** _____
_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____

Are parents/caregivers working outside home? ☐ Yes ☐ No
Child care/after school care _____
_____
Grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Exposure to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

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_____
_____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Indicators of Serious Emotional or Behavioral Disturbance *(✓ Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Does not achieve satisfactorily due to poor attention or high activity level; special accommodations are needed or implemented
- ☐ Inappropriate behavior resulting in disruption to others
- ☐ Deliberate damage to home
- ☐ On more than one occasion, committed acts that would be considered delinquent if child were older (e.g., vandalism, defacing property, threatening aggression, shoplifting other than minor items such as candy)
- ☐ Repeatedly and intentionally plays with fire such that damage to property or person could result
- ☐ Often mean or nasty to other people and animals
- ☐ Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys, bullies, teases, shoves)
- ☐ Often plays alone even when there are opportunities for peer play; would rather be alone
- ☐ Extremely tense or fearful (e.g., overreacts to sounds or noises)
- ☐ Persistent self-criticism or feeling of worthlessness
- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Pre-occupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources.

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia 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	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ 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	_____

Possible 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, Developmental and Mental Health, School, Physical Growth and Development, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

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 ☐ 8 years of age ☐ 9 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

9 and 10 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement_____ ☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Medical History

☐ Initial Screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No

_____

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

_____

_____

Psychosocial/Behavioral

What is your family living situation_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

Are parents/caregivers working outside home? ☐ Yes ☐ No

Child care/after school care _____

_____

Grade in school_____

Favorite subject_____

Any problems?_____

Activities outside school_____

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Exposure to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Concerns about speech, learning, social or motor skills _____

_____

Concerns about depression and/or anxiety_____

_____

Traumatic Stress Reactions/PCL-C

Positive screen = numbered responses 4 or greater

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

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 ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die

☐ Frequently mean to other people or animals

☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)

☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)

☐ Frequent use of profane, vulgar, or curse words to household members

☐ Deliberate damage to home

☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)

☐ Marked changes in moods that are generally intense and abrupt

☐ Friendships change to mostly substance users

☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes

☐ Currently at risk of confinement because of frequent or serious violations of law

☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No

Fruits/vegetables/lean protein per day_____

☐ Vitamins_____

☐ Normal elimination_____

☐ Physical activity/exercise an hour most days

Type of physical activity/exercise _____

Normal sleeping patterns? ☐ Yes ☐ No

Hours of sleep each night?_____

Oral Health

Date of last dental visit_____

Current oral health problems _____

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 10 years)*

R _____ L _____

Wears glasses? ☐ Yes ☐ No

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Hearing Screen (*Objective 10 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 9 and 11 years

****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	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ 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	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible 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, Development and Mental Health, School, Physical and Growth Development, 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)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 9 and 11 years and/or high risk)***
☐ Other _____

Referrals
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____

☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

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 ☐ 10 years of age ☐ 11 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

Screen Date_____

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

11, 12, 13 and 14 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Kinship Placement_____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 12 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 11 and 14 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about speech, learning, social and/or motor skills
_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Family Planning Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic screen
☐ **Family health history reviewed** _____
_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are parents/caregivers working outside home? ☐ Yes ☐ No
Child care/after school care _____
Grade in school_____
Favorite subject_____

Any problems_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor
☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes/Vaping ☐ *Chew ☐ Passive Smoke Risk
☐ *Alcohol use_____
☐ *Drug use (prescription or otherwise)_____
If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

(13 and 14 years)
Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No
Are you sexually active? ☐ Yes ☐ No
Method of contraception _____
Do you have children? ☐ Yes ☐ No _____
_____

Traumatic Stress Reactions/PCL-C
Positive screen = numbered responses 4 or greater
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)
Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Depression Screen/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If Positive see Periodicity Schedule for link to PHQ-9
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)

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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 ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial ☐ Emotional loss ☐ Health insurance
☐ Other_____
_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals
- ☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
- ☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
- ☐ Frequent use of profane, vulgar, or curse words to household members
- ☐ Deliberate damage to home
- ☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
- ☐ Marked changes in moods that are generally intense and abrupt
- ☐ Friendships change to mostly substance users
- ☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Currently at risk of confinement because of frequent or serious violations of law
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 9 and 11 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV 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	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ 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	_____

If female:

LMP_____	☐ Regular	☐ Irregular
Bleeding	☐ Normal	☐ Heavy
Cramping	☐ No	☐ Slight ☐ Severe

Possible 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 Determents of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child Visit ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 9 and 11 years and/or high risk)***
☐ STI test *(if sexually active and/or high risk)*
☐ HIV test *(if sexually active and/or high risk)*
☐ Other _____

Referrals
See page 1, school requirements

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 years of age ☐ 13 years of age
☐ 14 years of age ☐ 15 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

15, 16 and 17 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Kinship Placement_____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ N/A ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 15 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective, once between 15 and 17 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

☐ **Developmental Surveillance**
Concerns about speech, learning, social and/or motor skills_____
_____

Referrals:
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Family Planning Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic screen
☐ **Family health history reviewed** _____
_____
Currently receiving mental/behavioral health services? ☐ Yes ☐ No
_____
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:_____
_____

Psychosocial/Behavioral

What is your living situation?_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about your family meeting basic needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you still in school? ☐ Yes ☐ No Working? ☐ Yes ☐ No
What are your future plans?_____
_____

What interests do you have outside of school and/or work? _____
_____

☐ *Tobacco use ☐ Cigarettes # per day_____
☐ E-Cigarettes/Vaping ☐ *Chew ☐ Passive Smoke Risk
☐ *Alcohol use_____
☐ *Drug use (prescription or otherwise)_____
If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
Do you wear protective gear, including seat belts? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No
Are you sexually active? ☐ Yes ☐ No
Method of contraception _____
Do you have children? ☐ Yes ☐ No _____
_____

Traumatic Stress Reactions/PCL-C
Positive screen = numbered responses 4 or greater
Feelings over the past 2 weeks: (✓ *Check one for each question)*
Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)
Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Depression Screen/Patient Health Questionnaire (PHQ-2)
Positive screen = numbered responses 3 or greater
If Positive see Periodicity Schedule for link to PHQ-9
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)

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

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 ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial ☐ Emotional loss ☐ Health insurance
☐ Other_____
_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals
- ☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
- ☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
- ☐ Frequent use of profane, vulgar, or curse words to household members
- ☐ Deliberate damage to home
- ☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
- ☐ Marked changes in moods that are generally intense and abrupt
- ☐ Friendships change to mostly substance users
- ☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Currently at risk of confinement because of frequent or serious violations of law
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 17 and 20 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV Risk**
☐ Low risk ☐ High risk
HIV test required once between 15 and 18 years

****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	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ 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	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible 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, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety
☐ Discussed ☐ Handouts Given

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 17 and 20 years and/or high risk)***
☐ STI test *(if sexually active and/or high risk)*
☐ **HIV test *(once between 15 and 18 years, if sexually active and/or high risk)***
☐ Other _____
_____

Referrals
See page 1, school requirements

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 ☐ 16 years of age ☐ 17 years of age
☐ 18 years of age ☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature

Screen Date_____

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

18, 19 and 20 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ N/A ☐ Parent ☐ Grandparent ☐ Other _____

Medical History

☐ Initial Screen ☐ Periodic screen

☐ **Family health history reviewed** _____

_____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No

_____

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

_____

_____

Psychosocial/Behavioral

What is your living situation_____

_____

Are you in school? ☐ No ☐ High school ☐ College/vocational

Working? ☐ Yes ☐ No _____

What are your future plans?_____

_____

What interests do you have outside of school and/or work? _____

_____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

_____

☐ *Tobacco use ☐ Cigarettes # per day_____

☐ E-Cigarettes/Vaping ☐ *Chew ☐ Passive Smoke Risk

☐ *Alcohol use_____

☐ *Drug use (prescription or otherwise)_____

If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools

☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No

Are you sexually active? ☐ Yes ☐ No

Method of contraception _____

Do you have children? ☐ Yes ☐ No _____

_____

Traumatic Stress Reactions/PCL-C

Positive screen = numbered responses 4 or greater

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Depression Screen/Patient Health Questionnaire (PHQ-2)

Positive screen = numbered responses 3 or greater

If Positive see Periodicity Schedule for link to PHQ-9

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)

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 ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die

☐ Frequently mean to other people or animals

☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)

☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)

☐ Frequent use of profane, vulgar, or curse words to household members

☐ Deliberate damage to home

☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)

☐ Marked changes in moods that are generally intense and abrupt

☐ Friendships change to mostly substance users

☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes

☐ Currently at risk of confinement because of frequent or serious violations of law

☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/vegetables/lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

Oral Health
Date of last dental visit_____
Current oral health problems _____

Vision Acuity Screen: *(Subjective 18-20 years)*
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective once between 18 and 20 years)*
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ

R ear: _____ 6000HZ ____ 8000HZ
L ear: _____ 6000HZ ____ 8000HZ
Wears hearing aids? ☐ Yes ☐ No

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 17 and 20 years

***STI Risk**
☐ Low risk ☐ High risk

***HIV Risk**
☐ Low risk ☐ High risk
HIV test required once between 15 and 18 years

****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	_____
Neck	☐ N ☐ Abn	_____
Eyes	☐ 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	_____

If female:
LMP_____ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible 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, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 17 and 20 years and/or high risk)***
☐ STI test *(if sexually active and/or high risk)*
☐ **HIV test *(once between 15 and 18 years, if sexually active and/ or high risk)***
☐ **Hepatitis C Virus Test *(once between 18 and 79 years)***
☐ Other _____
_____

Referrals
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Substance abuse - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____

☐ Family Planning Program (FPP) **1-800-642-9704**
☐ Children with Special HealthCare Needs (CSHCN) **1-800-642-9704**
☐ Transition to adult-oriented health care/medical home

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 ☐ 19 years of age ☐ 20 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

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