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 _____ ☐ Child with special health care needs_____

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

Medical History

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

_____

☐ **Family health history reviewed** _____

_____
Concerns and/or questions_____

_____

Social/Psychosocial History

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? _____

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_____

_____
_____
_____

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
Concerns and/or questions_____

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Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)_____

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
☐ Breast feeding- Frequency _____
☐ Bottle feeding- Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Place on back to sleep_____
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	_____
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 ☐ Yes ☐ No
Concerns and/or questions _____

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Continue on page 2

Name____ DOB____________________ Age____________ Sex: ☐ M ☐ F

Anticipatory Guidance

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

Social Determinants of Health

- ☐ Living situation and food security
- ☐ Environmental tobacco exposure
- ☐ Intimate partner violence
- ☐ Maternal alcohol and substance use
- ☐ Family Support
- ☐ Parent(s)-newborn relationship

Parental/Family Health and Well-being

- ☐ Maternal health and nutrition
- ☐ Transitioning home
- ☐ Sibling adjustments/relationships

Newborn Behavior and Care

- ☐ Baby care (Infant supplies, skin, and cord care)
- ☐ Illness prevention (hand washing, outings and sun protection)
- ☐ Calming your baby
- ☐ Early brain development (singing, talking and reading to child)
- ☐ Emergency Care

Nutrition and Feeding

- ☐ General guidance on feeding
- ☐ Breastfeeding guidance
- ☐ Formula feeding guidance

Safety

- ☐ Car seat safety
- ☐ Heatstroke prevention
- ☐ Safe sleep
- ☐ Pets
- ☐ Safe home environment

☐ Other

____

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**

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 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