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 _____ ☐ Child with special health care needs_____

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

Medical History

☐ Initial screen ☐ Periodic screen

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

_____

_____

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

Social/Psychosocial History

What is your family's living situation?_____

_____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

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

_____

Who do you contact for help and/or support?_____

_____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care_____

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

_____

_____

_____

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_____

_____

_____

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol

☐ Drugs (prescription or otherwise)_____

☐ Access to firearm(s)/weapon(s)

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

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

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

☐ Breast feeding; 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_____

Concerns and/or questions_____

_____

_____

_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**

Hemoglobin/hematocrit required at 12 months

***Lead Risk**

Blood lead required at 12 months

***Tuberculosis Risk**

☐ Low risk ☐ High risk

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

Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____

Anticipatory Guidance

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

Social Determinants of Health

- ☐ Living situation and food security
- ☐ Tobacco, alcohol, and drugs
- ☐ Social connections with family, friends, child care, home visitation program staff, and others

Establishing Routines

- ☐ Adjustment to child's developmental changes and behavior
- ☐ Family time
- ☐ Bedtime, naptime, and teeth brushing
- ☐ Media

Feeding and Appetite Changes

- ☐ Self-feeding
- ☐ Continued breastfeeding and transition to family meals
- ☐ Nutritious foods

Establishing a Dental Home

- ☐ First dental checkup and dental hygiene

Safety

- ☐ Car safety seats
- ☐ Falls
- ☐ Drowning prevention and water safety
- ☐ Sun protection
- ☐ Pets
- ☐ Safe home environment: poisoning

☐ **Other**

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**

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 ☐ 15 months of age

☐ Other_____

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

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title