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 ____________________ ☐ 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?______________________

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______________________________

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 ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Feeling down, depressed, or hopeless
☐ Not at all ☐ Several days(1) ☐ More than ½ the days(2) ☐ Nearly every day(3)

Concerns and/or questions______________________________

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

Concerns and/or questions______________________________

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

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breast feeding; 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____________________
Concerns and/or questions____________________

****See Periodicity Schedule for Risk Factors***

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

Continue on page 2

West Virginia Department of Health & Human Resources Bureau for Public Health

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
- ☐ Environmental risk (lead)
- ☐ Family relationships and support
- ☐ Child care

Infant Behavior and Development
- ☐ Infant self-calming
- ☐ Parent-infant communication
- ☐ Consistent daily routines
- ☐ Media
- ☐ Playtime

Oral Health
- ☐ Maternal oral health
- ☐ Teething and drooling
- ☐ Good oral hygiene (no bottle in bed)

Nutrition and Feeding
- ☐ General guidance on feeding
- ☐ Feeding choices (avoid grazing)
- ☐ Delaying solid foods
- ☐ Breastfeeding guidance
- ☐ Supplements and over-the-counter medications
- ☐ Formula feeding guidance

Safety
- ☐ Car safety seats
- ☐ Safe sleep
- ☐ Safe home environment

☐ **Other**

____

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**

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 ☐ 6 months of age

☐ Other________________________

☐ Screen has been reviewed and is complete

____

Please Print Name of Facility or Clinician

____

Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health