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 ______________________ ☐ Child with special health care needs______________________

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization______________ ☐ Other ______________

Medical History

☐ Initial screen ☐ Periodic screen
Birth weight______________ Discharge weight______________
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:______________________________

☐ 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______________________________

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 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
Concerns and/or questions______________________________

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol ☐ Drugs (prescription or otherwise)______________________
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
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breast feeding; 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______________________
Concerns and/or questions______________________________

***See Periodicity Schedule for Risk Factors**

***Tuberculosis Risk**
☐ 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	______
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
- ☐ Environmental tobacco exposure
- ☐ Dampness and mold
- ☐ Radon
- ☐ Pesticides
- ☐ Intimate partner violence
- ☐ Maternal alcohol and substance abuse
- ☐ Family support/help

Parental/Family Health and Well-being
- ☐ Postpartum checkup
- ☐ Maternal depression
- ☐ Family relationships

Infant Behavior and Development
- ☐ Sleeping and waking
- ☐ Fussiness and attachment
- ☐ Media (distract from child's care)
- ☐ Playtime
- ☐ Medical home after hours support

Nutrition and Feeding
- ☐ Feeding plans and choices
- ☐ General guidance on feeding
- ☐ Breast feeding guidance
- ☐ Formula feeding guidance

Safety
- ☐ Car seat safety
- ☐ Safe sleep
- ☐ Preventing falls (changing table, couch, bed)
- ☐ Emergency care (CPR)

☐ Other

____

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**

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 ☐ 2 months of age

☐ Other______________________________

☐ Screen has been reviewed and is complete

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Please Print Name of Facility or Clinician

____

Signature of Clinician/Title

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