

Screen Date _____

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

24 Month Form

Name _____ DOB _____ Age _____ Sex: M F Race/Ethnicity _____

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 _____

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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

*Hepatitis B 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)
 - Hepatitis B Screen (HBsAG) (if high risk)
 - Other _____
- Referrals**
- Developmental Dental Blood lead \geq 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 dhr.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

