West Virginia Department of Health and Human Resources Screen Date 3 Year Form Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen DOB Age Sex: 🗆 M 🗆 F Name Weight Height BMI Pulse BP Resp Temp Pulse Ox (optional) Allergies D NKDA Current meds Done □ Foster Child ______ □ Child with special health care needs______ □ IEP/section 504 in place______ Accompanied by Derent Derent Derent Foster parent Dester organization Deter **Oral Health** Immunizations: Attach current immunization record Developmental Date of last dental visit □ UTD □ Given, see immunization record □ Entered into WVSIIS **Developmental Surveillance** (\checkmark Check those that apply) Current oral health problems S □ Child can enter bathroom and urinate by himself/herself □ Child chool Entry Requirements **Referrals**: Developmental can put on coat, jacket or shirt by themselves
Child can eat independently
Child can engage in imaginative play
Child can Mental/behavioral health/trauma- Help4WV.com/1-844-435-7498 play in cooperation and share
Child can use 3 word sentences Fluoride varnish applied (apply every 3 to 6 months) □ Dental □ Vision □ Hearing □ Child can speak in words that are 75% understandable to strangers □ Other □ Yes □ No □ Child can tell you a story from a book or TV □ Child can compare □ Children with Special HealthCare Needs (CSHCN) things using words like bigger or shorter
Child can understand Vision Acuity Screen: 1-800-642-9704 simple prepositions, such as on or under
Child can pedal a tricycle R L UTO (retest in 6 months) □ Women, Infants and Children (WIC) **1-304-558-0030** □ Child can climb on and off couch or chair □ Child can jump Wears glasses? □ Yes □ No forward \Box Child can draw a single circle \Box Child can draw a person with head and 1 other body part
Child can cut with child scissors Hearing Screen (Subjective screen required) Concerns about child's behavior, speech, learning, social or motor Please Print Name of Facility or Clinician Do you think your child hears okay? □ Yes □ No skills Wears hearing aids? □ Yes □ No Signature of Clinician/Title The information above this line is intended to be released to meet school entry requirements Child care/after school care Medical History □ Drugs (prescription or otherwise) □ Initial Screen \Box Access to firearm(s)/weapon(s) \Box Has a firearm(s)/weapon(s) Periodic Screen How much **stress** are you and your family under **now**? Are the firearm(s)/weapon(s) secured? □ Yes □ No □ NA Recent injuries, surgeries, illnesses, visits to other providers and/or □ None □ Slight □ Moderate □ Severe counselors and/or hospitalizations: Witnessed violence/abuse □ Threatened with violence/abuse What kind of stress? (\checkmark Check those that apply) Scary experience that your child cannot forget □ Relationships (partner, family and/or friends) □ School/work □ Child care □ Drugs □ Alcohol □ Violence/abuse (physical, Family health history reviewed Do you utilize a car/booster seat for your child? □ Yes □ No emotional and/or sexual)
Family member incarcerated
Lack of Excessive television/video game/internet/cell phone use Concerns and/or questions □ Health insurance □ Other General Health Growth plotted on growth chart Social/Psychosocial History Is your child in school? □ Yes □ No _____ BMI calculated and plotted on BMI chart What is your family living situation Favorite thing about school Any problems? Family relationships □ Good □ Okay □ Poor Activities outside school Do you have concerns about meeting basic family needs daily and/or Peer relationships/friends Good Okay Poor monthly (food, housing, heat, etc.)?
Yes
No **Risk Indicators** (Check those that apply)

Are you and/or your partner working outside home?

Yes
No

Child exposed to □ Cigarettes □ E-Cigarettes □ Alcohol

Continue on page 2

Health

Sex: □ M □ F

DOB___

Plan of Care

Age

Nutrition/Physical Activity/Sleep

*See Periodicity Schedule for Risk Factors

*Anemia Risk (Hemoglobin/Hematocrit)

*Lead Risk

***Tuberculosis Risk** □ Low risk □ High risk

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance	$\Box N$	□ Abn _	
Skin	\Box N	□ Abn _	
Neurological	\Box N	□ Abn _	
Reflexes	\Box N		
Head	\Box N		
Neck	\Box N		
Eyes	\Box N	□ Abn _	
Red Reflex	\Box N		
Ocular Alignment	\Box N	□ Abn _	
Ears	\Box N	□ Abn _	
Nose	\Box N	□ Abn _	
Oral Cavity/Throat	\Box N	□ Abn _	
Lung	\Box N	□ Abn _	
Heart	\Box N	□ Abn _	
Pulses	\Box N	□ Abn _	
Abdomen	\Box N		
Genitalia	\Box N	□ Abn _	
Back	\Box N	□ Abn _	
Hips	\Box N		
Extremities	ΠN	□ Abn	

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
 Positive family interactions
 Work-life balance

Playing with Siblings and Peers

Play opportunities and interactive gamesSibling relationships

Encouraging Literacy Activities

Reading, talking, and singing togetherLanguage development

Promoting Healthy Nutrition and Physical Activity

Water, milk, and juice
 Nutritious foods
 Competence in motor skills and limits on inactivity

Safety

Car safety seats
 Choking prevention
 Pedestrian safety and falls from windows
 Water safety
 Pets
 Firearm safety

Other



Assessment I Well Child I Other Diagnosis

Labs

 Hemoglobin/hematocrit (*if high risk*)
 Blood lead (*if not completed at 12 and/or 24 months or high risk*) (*enter into WVSIIS*)
 TB skin test (*if high risk*)
 Other

Referrals See page 1, school requirements

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 □ 4 years of age □ Other

□ Screen has been reviewed and is complete

See page 1, school requirements for required signature

