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

5 Year Form

Name________________ DOB__________ Age________ Sex: M F Wt______ Ht______ BP______ Temp______ Pulse________ Screen Date__________

Allergies: □ NKDA ______________________________ Current Meds: □ None ______________________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________

Health conditions that may require care at school:______________________________

□ Vision Acuity Screen (obj) R__________ L __________
Wears glasses □ Yes □ No

□ Hearing Screen (obj)
25 db@ 20 db@
R ear:____500HZ R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ L ear:____1000HZ ____2000HZ _____4000HZ
Wears hearing aids □ Yes □ No

Oral Health Screen
Date of last dental visit__________________
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current dental problems:

□ Developmental Surveillance: *✓ Check those that apply*
Gross Motor:
□ Walks, climbs, runs □ May be able to skip
□ Up/down stairs alternating feet, without support
Fine Motor:
□ Copies ▲ or ■ □ Prints some letters
□ Draws figure w/head, arms and legs □ Dresses self
□ Has manual dexterity
Communication:
□ Able to recall parts of story □ Fluent speech
□ Uses complete sentences □ Speaks in short sentences
□ Uses future tense □ Second language spoken at home
Cognitive:
□ Knows address and phone # □ Can count on fingers
□ Follows 2-3 step instructions
□ Recognizes many letters of the alphabet
Social:
□ Listens to stories □ Follows rules
□ Plays interactive games with peers
□ Elaborate fantasy play/make believe/dress up

Immunizations: Attach current immunization record
□ UTD □ Given, see vaccine record
Referrals: □ Developmental □ Dentist □ Vision
□ Hearing □ Blood lead 10≥ug/dl □ CSHCN 1-800-642-9704
□ Other:

Provider signature required for validation
□ Risk indicators reviewed/screen complete

____
Please Print Name of Facility or Clinic

____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

- -

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change □ Family situation change

Parents working outside home? □ Mother □ Father
Child care? □ No □ Yes ____________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

School: Grade________ □ Attends school regularly □ N/A
□ Ability to separate from parents ______________
Likes most about school__________________
Likes least about school__________________
□ Gets along with other family members

□ GROWTH PLOTTED ON GROWTH CHART
□ BMI CALCULATED AND PLOTTED ON BMI CHART
□ Normal elimination
□ Normal sleep patterns
□ Appropriate behavior

Nutrition: □ Normal eating habits
□ Vitamins______________________
□ Passive smoking risk □ Yes □ No

✓ Check those that apply
Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

Lead Risk: □ Low risk □ High risk
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: *✓ Check those that apply*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Nose □ Ears □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible signs of abuse □ Yes □ No

Health Education:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships and community interaction
Other:

Assessment: □ Well Child □ Other diagnosis

Plan/Referrals:
For treatment plans requiring authorization, please complete the Medical Necessity Form on the reverse.

Labs: □ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 6 years of age □ Other

West Virginia Department of Health and Human Resources
HealthCheck Program
Preventive Health Screen

Name________________________________ DOB________________

Additional Documentation

Date________________ ☐ Interperiodic Screen (Check box if this is an encounter outside of the defined periodicity for this child)

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Medical Necessity Form

It is the responsibility of the ordering healthcare provider to complete this Medical Necessity Form (MNF) and provide adequate documentation or information of the plan of treatment. The healthcare provider then gives this information either to the patient or directly to the treatment provider. The treatment provider must be enrolled in West Virginia Medicaid.

A. Patient's Medical ID Number________________________________

B.

ICD-9 Code(s)	Clinical Diagnosis

C.

Item or Service Description	Length of Need (# of months)	Amt/Mo Requested

D. Clinical Indication(s) for Item(s) Requested:

____

____

E. Provider Certification
I certify that I have examined the member as part of an EPSDT periodic or interperiodic screen and the services requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not a convenience item for the member or any individual involved with the member's care. I certify that the member or his representative have been offered a choice of vendors.

________________________ ________________________
Print Provider/Clinic Name Provider Signature

________________________ ________________________
Medicaid D# Date

Official Use Only:

____

____