KAN Be Healthy (EPSDT) Screening Form

I.D. Number: _____

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T _____ P _____ R _____ BP _____

Weight _____ (lbs/kg) _____ th%

Length (Birth to 36 months) _____ cm/in

BMI _____

BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

Weight/Length _____ %

Standing Height (2 - 20 years) _____ cm/in

_____ th%

Head Circ (≤ 24 months) _____ cm/in

_____ th%

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.
☐ No changes in medical Hx unless indicated.
☐ Previous Hx reviewed from _____ visit.
☐ Patient currently in Foster care, no previous hx available.

Present Concern: _____

Medications: _____

Serious Illness/Accidents: ☐ No ☐ Yes (date & type) (including Hospital or ER visits) _____

Allergies (food & drug) _____

Birth History (Length, weight, complications, etc. - if known) _____

Operations: ☐ No ☐ Yes (date & type) _____

(Circle and indicate the relationship with disease / problem. P-Parent, G-Grandparent, B-Brother, S-Sister, Self)

Allergies (food & drug)		Drug or ETOH Abuse		Mental Illness	
Asthma		Earaches		Obesity	
Birth defects		Epilepsy/Seizures		Scoliosis/Arthritis	
Blood Disorder/ Sickle Cell		Headache		Speech, Visual, Hearing	
Cancer		High Blood Pressure		Ulcers/Colitis	
Colds/sore throat		Kidney/Liver Disease		Urinary/Bowel	
Diabetes		Lung Disease		Heart Disease/Stroke	

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	
Cardiovascular	☐	☐	
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Last eye exam date: _____ Eye tracking (< 4 yrs old) Pass ☐ Refer ☐ Comments:_____

Corneal Light Reflex Present:Yes ☐ No ☐ Distance Acuity(4-20 yrs) Tool used:_____ Score: Left____ Right____ Both____

Outer Inspection: Normal ☐ Abnormal ☐ Near Acuity(4-20) Tool used: :_____ Score: Left____ Right____ Both____

NUTRITION

☐ WIC participant

☐ Referred to WIC

☐ Breast Feeding ☐ Formula

Amount & how often: _____

Number of Servings per day

Bread/Cereal _____ Dairy _____

Fat/Sweet/Sugar _____ Fruit _____

Meat/Bean/Egg _____ Vegetable _____

Fluid Intake: water _____ oz. Soda _____

Milk _____ oz. Juice _____

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside

☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)

☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No

If "yes", then complete following :

1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No

Referred to:

LABORATORY

HGB or HCT(required at 12 mths, start of menses in girls, 11-20 yr in boys)

HGB results:_____ or HCT results:_____Date obtained:_____

WIC results?: Yes ☐ No ☐ Date:_____ Other Lab?_____

IMMUNIZATIONS

Copy of record in chart

Current ☐

Behind ☐

Unknown ☐

Requested from Parent ☐

Referred to VFC provider ☐

Needs: (circle)

HepB DTaP Flu

Hib IPV MMR

MCV4 MPSV4 PCV

Varicella HepA

Other:

DEVELOPMENTAL / EMOTIONAL

Developmental Screening Tool: (required for all children < 6 yrs of age)

Tool Used (in file): _____

Results Pass ☐ Delayed ☐

Not Screened (Comments Required)_____

Interpretation of screen: _____

Referred to :

Developmental Emotional Observations or Tool: _____(Age 6-20 yrs)

Sleep Habits _____ Tired / overactive? _____

Discipline: _____ Vocational concerns? _____

Peer Interaction: _____

Grade Level _____ Average Marks _____

Special Education/Needs: _____

Any emotional or behavioral problems? _____

Emotional Observations:_____

DENTAL

Sees Dentist? Yes ☐ No ☐

Last dental exam date: ____/____/____

times brushes/day: _____

Dental Referral (annualy at a minimum 0-20yr)

Yes ☐ No ☐

HEARING SCREEN

Minimally must document completion and findings of paper hearing screen or audiometric sweep screen

Hearing Health History ≥ 5: Pass ☐ Refer ☐

Risk Indicators for Hearing Loss < 5 Pass ☐ Refer ☐

Hearing Developmental Scales < 5 Pass ☐ Refer ☐

Audiometric Sweep Screen: Left_____ Right_____

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline
2. Oral /Dental
3. Development
4. Physical Activity
5. Family Planning
6. Immunizations
7. Lifestyle
8. Nutrition
9. Parenting
10. Safety/Poisions
11. Substance Abuse
12. Self Testicular Exam
13. Self Breast Exam
14. Sexuality
15. Exercise
16. Weapon Safety
17. Other:_____

RESULTS/PLAN OF CARE

Screening Results: _____

Plan/Referrals (dental, vision, hearing, dietary, etc): _____

Recommended: _____

Return Date: / /

Parent/caregiver informed of KBH screen findings and verbalizes understanding of teachings.

Yes ☐ No ☐

Date: / /

Screening Providers Signature: _____

(Licensed Physician, ARNP , PA, or Registered Nurse trained to perform KAN Be Healthy screens)

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