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

2 Month Form

Name_____DOB_____Age_____Sex: M F Wt_____Ht_____HC_____Temp_____Pulse_____Screen Date_____

Allergies: □ NKDA _____ Current Meds: □ None _____

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

History: □ No change
Newborn metabolic screen □ **NL**
Concerns and questions:

Follow up on previous concerns:

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

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes _____
Other changes since last visit:

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

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency_____
□ Bottle feeding; Amount_____ Frequency _____
□ Formula_____
□ Vitamins _____
Comments:

□ Passive Smoking Risk: □ Yes □ No

□ **Developmental Surveillance:** ✓*Check those that apply*
Gross Motor:
□ Lifts head when prone
□ Holds head erect for periods when held upright
□ Grasps objects

Sensory:
□ Responds to sounds, attentive to voices
□ Follows objects with eyes, shows interest
Communication:
□ Coos
□ Different cries for different needs
Social:
□ Social smile, smiles responsively
□ Shows pleasure in interactions with adults
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested

□ Current oral health problems:

Physical Examination: ✓= *Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	
□ Oral Cavity/Throat		
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back	□ Hips	□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals: □ Developmental
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 4 months of age □ Other

_____
Please print Name of Facility or Clinician

_____
Signature of Clinician/Title