Screen Date____________________

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

24 Month Form

Name______________________________ DOB__________________ Age__________ Sex: ☐ M ☐ F

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

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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

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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

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☐ **Autism screening completed with an Autism Specific Tool**
☐ M-CHAT-R/F ☐ Other tool______________
Results in child's record ☐ Yes ☐ No

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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 ______________

Continue on page 2

Screen Date____________________

Name____________________ DOB____________________ Age____________ Sex: ☐ M ☐ F

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

****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

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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)*
☐ 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 dhhr.wv.gov/healthcheck.

Follow Up/Next Visit ☐ 30 months of age

☐ Other____________________

☐ Screen has been reviewed and is complete

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Please Print Name of Facility or Clinician

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Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health