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

30 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
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

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**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins _____
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

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

□ **Developmental Surveillance & Screening:**
Standardized Screening Tool:
□ **ASQ3 Other:**_____
Results in chart/record □ Yes □ No
Comments:

Ability to separate from parents □ Yes □ No

Gets along with other family members □ Yes □ No

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
Date of last dental visit_____
Water source:
□ Public
□ Well □ Tested
Fluoride □ Yes □ No
□ Current oral health problems:

Physical Examination: ✓= *Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head		□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	□ Oral Cavity/Throat
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back		□ 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, sexuality, injury and violence prevention, social competence, 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.

□ BTT transition planning

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

Referrals: □ Developmental □ Dentist
□ Blood lead ≥ 10 ug/dl
□ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 3 years of age □ Other

_____
Please print Name of Facility or Clinician

_____
Signature of Clinician/Title

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