Screen Date_____

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

Newborn to 1 Week Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F **Race/Ethnicity**_____

Weight _____ Length_____ Weight for Length_____ 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

☐ **Family health history reviewed** _____

_____

Concerns and/or questions_____

_____

In utero substance exposure ☐ Yes ☐ No _____
Maternal Hep C exposure ☐ Yes ☐ No _____
Gestational age_____ Maternal labs_____
Complications_____
Birth history ☐ NSVD ☐ C-section Breech ☐ Yes ☐ No
Birth weight_____ Discharge weight_____
High birth score ☐ Yes ☐ No _____
Newborn metabolic screen ☐ NL
Newborn bilirubin screen ☐ NL
Newborn critical congenital heart disease pulse oximetry _____
Newborn hearing screen ☐ Pass ☐ Fail ☐ Pending ☐ Retest

_____

Hepatitis B Risk *(See Periodicity Schedule for Risk Factors)*
☐ Low risk ☐ High risk

Psychosocial/Behavioral

What is your family's living situation?_____

_____

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No _____

_____

_____

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 plans? _____

_____

_____

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol
☐ Drugs (prescription or otherwise)_____

_____

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 mind being held by other people?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child cry a lot?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have a hard time calming down?
☐ Not at all ☐ Somewhat ☐ Very much
Is your child fussy or irritable?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to comfort your child?
☐ Not at all ☐ Somewhat ☐ Very Much
Is it hard to put your child to sleep?
☐ Not at all ☐ Somewhat ☐ Very much
Is it hard to get enough sleep because of your child?
☐ Not at all ☐ Somewhat ☐ Very much
Does your child have trouble staying asleep?
☐ Not at all ☐ Somewhat ☐ Very much

_____
_____
_____
_____
_____
_____
_____
_____
_____

Developmental

Developmental Surveillance (✓*Check those that apply)*
Social Language and Self–help ☐ Child has periods of wakefulness ☐ Child looks at and studies you when awake ☐ Child looks in your eyes when being held ☐ Child calms when picked up ☐ Child responds differently to soothing touch and alerting touch
Verbal Language ☐ Child communicates discomfort through crying, facial expressions and body movements ☐ Child moves or calms to your voice
Gross Motor ☐ Child moves in response to visual or auditory stimuli ☐ Child moves arms and legs symmetrically and reflexively when startled ☐ Child lifts head briefly when on stomach and can turn it to the side
Fine Motor ☐ Child keeps hands in fist ☐ Child automatically grasps others' fingers or objects

_____
_____
_____
_____

General Health

☐ Growth plotted on growth chart
Do you think your child sees okay? ☐ Yes ☐ No

Oral Health
Water source: ☐ Public ☐ Well ☐ Tested

Nutrition/Sleep
☐ Breastfeeding - Frequency _____
☐ Bottle feeding - Amount_____ Frequency_____
☐ Formula _____
☐ Normal elimination_____
☐ Place on back to sleep_____

_____

Continue on page 2

Name______________________________ DOB__________________ Age__________ Sex: ☐ M ☐ F

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance ☐ N ☐ Abn ____________
Skin ☐ N ☐ Abn ____________
Neurological ☐ N ☐ Abn ____________
Reflexes ☐ N ☐ Abn ____________
Head ☐ N ☐ Abn ____________
Fontanelles ☐ N ☐ Abn ____________
Neck ☐ N ☐ Abn ____________
Eyes ☐ N ☐ Abn ____________
Red Reflex ☐ 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 ____________
Umbilical cord ☐ N ☐ Abn ____________
Genitalia ☐ N ☐ Abn ____________
Back ☐ N ☐ Abn ____________
Hips ☐ N ☐ Abn ____________
Extremities ☐ N ☐ Abn ____________
Jaundice ☐ Yes ☐ No
Possible Signs of Abuse/Neglect ☐ Yes ☐ No
Concerns and/or questions ____________

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Parental/Family Health and Well-Being, Newborn Behavior and Care, Nutrition and Feeding, and Safety

☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other ____________

Referrals ☐ Developmental
☐ Other ____________

☐ Right from the Start (RFTS) **1-800-642-9704**
☐ 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 ☐ 1 month of age ☐ 2 months of age
☐ Other____________

☐ Screen has been reviewed and is complete

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Please Print Name of Facility or Clinician

West Virginia Department of HEALTH