WellCare Health Plans

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Well Child Exam

Member Name:________________________________ Age:___	Provider Name: ______________________________________
Chief Complaints: ____ ____ ____	**Vital Signs:** Temp_____BP______Resp_______ Pulse____**Ht**_____**Wt**_____**BMI kg/m2**_______ **BMI Percentile**____________ Head Circumference________
Feeding:________ **Sleep:** ________ **Elimination**: ________	**Allergies:** ____
Initial History/Interval History/Birth History: ____ **Surgical History:** ____________________________________	**Medications:** ____ ____ ____

☐ **Documentation of Growth Charts with each visit** (separate form)

Nutritional Assessment: (each visit) Formula_____ Breast _____ Cup_____ Adequate Fruits/Vegetables______ Calcium Source_______ ☐**Counseling for nutrition**	**Social History:** ☐**5-2-1-Almost None** Language____________ School _____________ Tobacco Use/Exposure ______ Alcohol Use_____ Substance Abuse______ Guardianship _________ ☐**Counseling/Physical Activity** ________Sports__________
Lead Risk Assessment: (6 months - 6 years) **Questionnaire use: (each visit)** Negative____ Positive____ Blood testing results: 12 months_____ 2 years_____	**TB Risk Assessment:** (infancy, childhood, and adolescent) **Questionnaire use: (each visit)** Negative____ Positive____ / If positive, date of PPD______ ☐ Reported to Health Dept.

Developmental Assessment: (each visit)

1–3 months	4–6 months	7–9 months	10–12 months	13–15 months	16–18 months	19–24 months
☐Lifts head ☐Follows past midline ☐Laughs & smiles ☐Tight grasp ☐Coos	☐Rolls over ☐Sits-no support ☐Grasp-reaches ☐Turns to voice ☐Reaches for toys	☐Pulls up/stands ☐Takes 2 cubes ☐Says mama/dada ☐Waves bye ☐Looks for objects	☐Stands alone for 5 sec ☐Bangs blocks ☐Babbles ☐Finger grasp ☐Pat-a-cake	☐Walks well ☐Bends ☐Puts block in cup ☐Says 1-3 words ☐Drinks from cup	☐Walks backwards ☐Runs ☐Scribbles ☐Says 3 words	☐Walks up steps ☐Makes tower 4-6 cubes ☐Points to pictures ☐Removes clothes
2–3 years	**4–5 years**	**6–7 years**	**8–10 years**	**11–13 years**	**14–17 years**	**18–21 years**
☐Wash/dry hands ☐Points to body parts ☐Jumps ☐Names colors ☐Throws ball	☐Balances on each foot ☐Draws person ☐Copies circle ☐Brushes teeth ☐Counts	☐Knows alphabet ☐Writes name ☐Knows right /wrong ☐Physical activity 1 hr.	☐Seeks in-dependence ☐Peer influence ☐Physical activity 1 hr. ☐Feels good about self	☐Seeks privacy ☐Self-image ☐Different sex friends ☐Physical activity 1 hr.	☐Outside activities ☐Takes risk ☐Physical activity 1 hr.	☐Self-confident ☐Friends are important ☐Thoughts of future ☐Questions rules

Vision Screening: **Referral:**_______________________________________

3–6 year ☐ Pass ☐ Fail R___ L___ B___ **8 year** ☐ Pass ☐ Fail R___ L___ B___ **10 year** ☐ Pass ☐ Fail R___ L___ B___	**12 year** ☐ Pass ☐ Fail R___ L___ B___ **15 year** ☐ Pass ☐ Fail R___ L___ B___ **18 year** ☐ Pass ☐ Fail R___ L___ B___

Hearing Screening: **Referral:**_______________________________________

NB ☐ Pass ☐ Fail Hospital results:_________	**8 year** ☐ Pass ☐ Fail R___ L___ 1000Hz____ 2000Hz____ 4000Hz____
4–6 year ☐ Pass ☐ Fail R___ L___ 1000Hz____ 2000Hz____ 4000Hz____	**10 year** ☐ Pass ☐ Fail R___ L___ 1000Hz____ 2000Hz____ 4000Hz____

Oral Health: **Referral:**_______________________________________

12 months: ☐Dental risk assessment	☐Annual dental visit ☐ Public Water Source
24 months: ☐Referral initiated	☐Fluoride varnish applied

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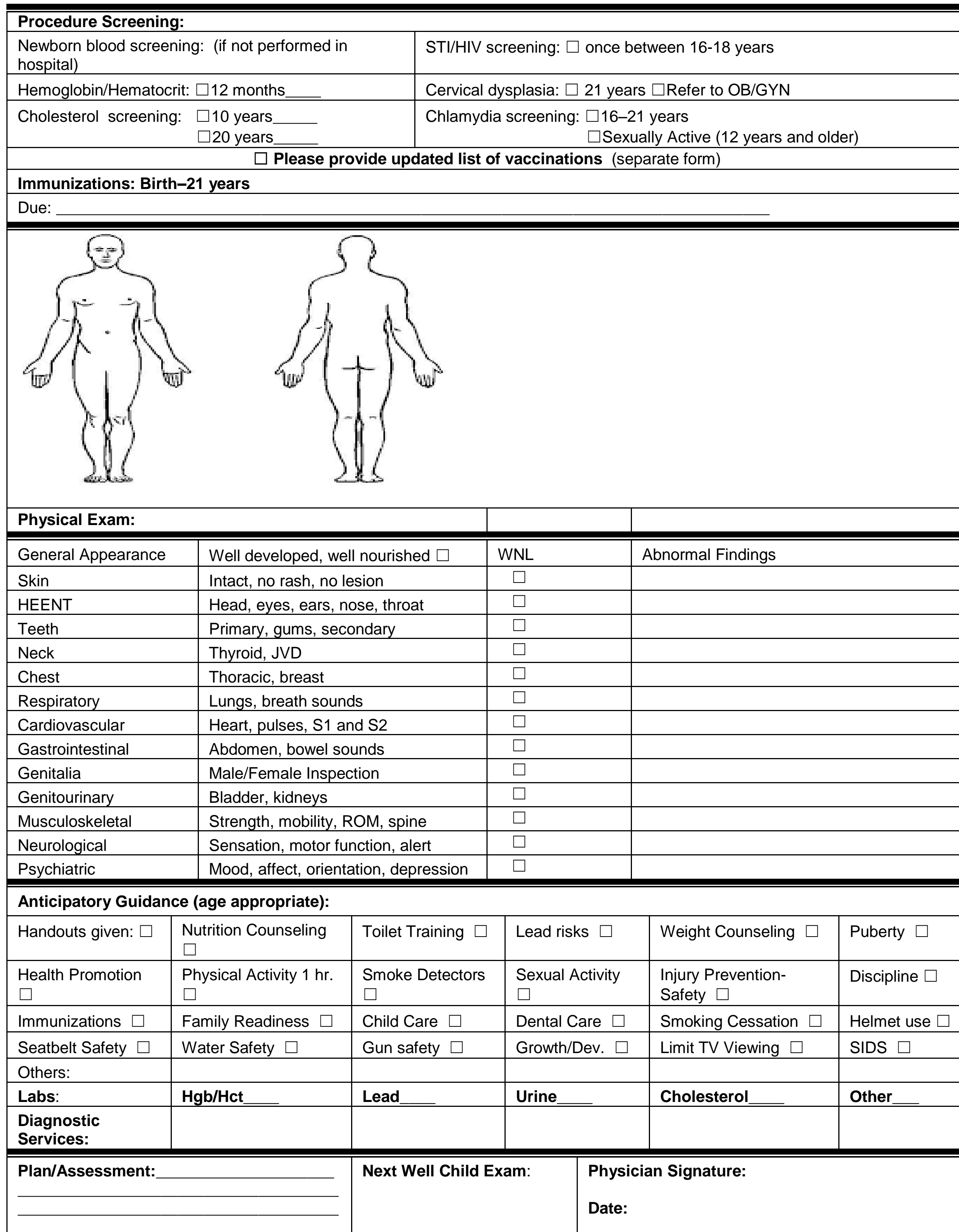
Procedure Screening:	
Newborn blood screening: (if not performed in hospital)	STI/HIV screening: ☐ once between 16-18 years
Hemoglobin/Hematocrit: ☐12 months____	Cervical dysplasia: ☐ 21 years ☐Refer to OB/GYN
Cholesterol screening: ☐10 years_____ ☐20 years_____	Chlamydia screening: ☐16–21 years ☐Sexually Active (12 years and older)
☐ **Please provide updated list of vaccinations** (separate form)	
Immunizations: Birth–21 years	
Due: ____	



Physical Exam:			
General Appearance	Well developed, well nourished ☐	WNL	Abnormal Findings
Skin	Intact, no rash, no lesion	☐	
HEENT	Head, eyes, ears, nose, throat	☐	
Teeth	Primary, gums, secondary	☐	
Neck	Thyroid, JVD	☐	
Chest	Thoracic, breast	☐	
Respiratory	Lungs, breath sounds	☐	
Cardiovascular	Heart, pulses, S1 and S2	☐	
Gastrointestinal	Abdomen, bowel sounds	☐	
Genitalia	Male/Female Inspection	☐	
Genitourinary	Bladder, kidneys	☐	
Musculoskeletal	Strength, mobility, ROM, spine	☐	
Neurological	Sensation, motor function, alert	☐	
Psychiatric	Mood, affect, orientation, depression	☐	

Anticipatory Guidance (age appropriate):					
Handouts given: ☐	Nutrition Counseling ☐	Toilet Training ☐	Lead risks ☐	Weight Counseling ☐	Puberty ☐
Health Promotion ☐	Physical Activity 1 hr. ☐	Smoke Detectors ☐	Sexual Activity ☐	Injury Prevention-Safety ☐	Discipline ☐
Immunizations ☐	Family Readiness ☐	Child Care ☐	Dental Care ☐	Smoking Cessation ☐	Helmet use ☐
Seatbelt Safety ☐	Water Safety ☐	Gun safety ☐	Growth/Dev. ☐	Limit TV Viewing ☐	SIDS ☐
Others:					
Labs:	**Hgb/Hct____**	**Lead____**	**Urine____**	**Cholesterol____**	**Other___**
Diagnostic Services:					

Plan/Assessment:____________________ ___________________________________ ___________________________________ ___________________________________	**Next Well Child Exam**:	**Physician Signature:** **Date:**

LHRN/ Quality Improvement Department/EPSDT/Well Child Exam/ 290415 / Note: form subject to change

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Lead Risk Screening Assessment Form for Children (6 months–6 years)

(Lead blood levels test at 12 months and 24 months)

Catch Up: Children between 36 months and 72 months (if not previously tested) must have a lead blood test regardless of low or high assessment.

- ☐ Does your child live in a house or attend a daycare that was built before 1978?
- ☐ Does your child live in or has he/she visited a house recently renovated, remodeled, or with peeling or chipping paint?
- ☐ Does your child have a sibling or playmate that is/has been treated for lead poisoning?
- ☐ Does your child live with an adult whose job or hobby involves exposure to lead?
- ☐ Does your child chew or eat non-food items like paint chips or dirt?
- ☐ Does your child have a parent that works in gardening, farming, or other lead potential exposure?
- ☐ Does your child receive home remedies such as Greta, Azarcon, Kohl, or Pay-loo-ah?
- ☐ Does anyone in the household use home or folk remedies or eat candies from Mexico, which may contain lead?
- ☐ Is your child a recent immigrant, refugee, or a member of a minority group?
- ☐ Does your child live near an active smelter, battery recycling plant or other industry that has potential lead exposure?

If yes to any questions, this child may be at a high risk of lead exposure. Please obtain lead blood testing and notify the local health department.

Provider Signature:	Date:

Tuberculosis (TB) Risk Assessment Screening Form

(Screening during 1, 6, 12 and 24 months of age; then annually 3-21 years)

- ☐ Has your child been in close proximity/contact with someone who has TB or treated for TB?
- ☐ Has your child had a chest x-ray for suspected TB?
- ☐ Has your child recently traveled to a foreign country with known TB cases? (Asia, Middle East, Africa, or Latin America)
- ☐ Has your child been diagnosed with HIV/AIDS?
- ☐ Has your child been in close contact with someone who is/was incarcerated in past 5 years?
- ☐ Does your child live in a group home, foster home, or orphanage?
- ☐ Has your child been exposed to the following individuals: HIV infected, homeless, nursing home residents, illicit drug users, or migrant farm workers?

If yes to any questions, this child may be at a high risk of TB exposure. Please obtain TB testing and notify the local health department.

Provider Signature:	Date:

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