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)

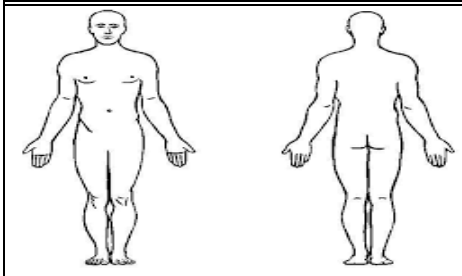
1–3 months	4–6 months	7–9 months	10–12 months	13–15 months	16–18 months	19–24 months
☐Lifts head ☐Follows past midline ☐Laughs & smiles ☐Tight grasp ☐Coos	☐Rolls over ☐Sits-no support ☐Grasp-reaches ☐Turns to voice ☐Reaches for toys	☐Pulls up/stands ☐Takes 2 cubes ☐Says mama/dada ☐Waves bye ☐Looks for 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

WellCare Health Plans

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

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 ☐	Child Care ☐	Sexual Activity ☐	Growth/Dev. ☐	Discipline ☐
Immunizations ☐	Family Readiness ☐	SIDS ☐	Dental Care ☐	Smoking ☐ Cessation	Helmet use ☐
Injury Prevention/Safety ☐	Smoke Detectors ☐	Gun safety ☐	Seatbelt safety ☐	Limit TV Viewing ☐	Water safety ☐
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

WellCare Health Plans

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

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.

Y ☐ N ☐ Does your child live in a house or attend a daycare that was built before 1978?

Y ☐ N ☐ Does your child live in or has he/she visited a house recently renovated, remodeled, or with peeling or chipping paint?

Y ☐ N ☐ Does your child have a sibling or playmate that is/has been treated for lead poisoning?

Y ☐ N ☐ Does your child live with an adult whose job or hobby involves exposure to lead?

Y ☐ N ☐ Does your child chew or eat non-food items like paint chips or dirt?

Y ☐ N ☐ Does your child have a parent that works in gardening, farming, or other lead potential exposure?

Y ☐ N ☐ Does your child receive home remedies such as Greta, Azarcon, Kohl, or Pay-loo-ah?

Y ☐ N ☐ Does anyone in the household use home or folk remedies or eat candies from Mexico, which may contain lead?

Y ☐ N ☐ Is your child a recent immigrant, refugee, or a member of a minority group?

Y ☐ N ☐ 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)

Y ☐ N ☐ Has your child been in close proximity/contact with someone who has TB or treated for TB?

Y ☐ N ☐ Has your child had a chest x-ray for suspected TB?

Y ☐ N ☐ Has your child recently traveled to a foreign country with known TB cases?
(Asia, Middle East, Africa, or Latin America)

Y ☐ N ☐ Has your child been diagnosed with HIV/AIDS?

Y ☐ N ☐ Has your child been in close contact with someone who is/was incarcerated in past 5 years?

Y ☐ N ☐ Does your child live in a group home, foster home, or orphanage?

Y ☐ N ☐ 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: