Well Care (Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)) Exam Forms and Anticipatory Guidance

The Well Care (EPSDT) Exam Forms, are revised as of 2/06 as are the Anticipatory Guidance tables that accompany the forms. These forms and tables should be used from birth through age 20. The new forms consist of full pages for each age or age range to give providers more room to record comments regarding the findings from each screen and an expanded anticipatory guidance section. These forms contain the recommended elements of screens, recommended immunizations and anticipatory guidance suggested by the American Academy of Pediatrics, the Centers for Disease Control, the American Medical Association and other professional organizations. Additional information about the elements of the screens and the anticipatory guidance questions can be found at http://brightfutures.aap.org/web/. This website offers information for medical professionals, public health professionals and parents and other interested community members about child development and age-appropriate well care.

The Anticipatory Guidance Tables attached have been revised and expanded. These tables, like the revised anticipatory guidance sections of the Well Care EPSDT Tracking Forms, will assist providers in providing comprehensive age-appropriate anticipatory guidance at each well child visit. They provide easier-to-read and slightly more detailed lists of the elements of anticipatory guidance appropriate for each exam and can serve as a useful reference.

The Revised Well Care EPSDT Exam Forms have been approved for use by DSS, and all the managed care organizations in HUSKY A, Connecticut's Medicaid Managed Care, and HUSKY B, the Connecticut SCHIP Program. These forms include all the required parts of an EPSDT screen. The Department encourages all providers of EPSDT screens to use the new Well Care EPSDT Tracking Forms which can assist providers in delivering comprehensive well child screens.

Coding

These forms list the appropriate preventative screening procedure code(s) , from the series 99381-99395 for each age range which should be used to obtain reimbursement for an EPSDT screen, in the upper right hand corner of the page. Other ways to report well child exams include:

- An Evaluation and Management Code from the series 99201-99215 with an appropriate well care diagnosis (*V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9*)

- In a clinic setting, revenue center codes 51X with an appropriate well child care diagnosis (*V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9*) to indicate provision of a comprehensive well care visit.

- T1015, the general clinic encounter code must be combined with either age-appropriate preventative care codes, or E and M codes combined with a well-child care diagnosis, to indicate a well care visit.

Note: Use of these other codes instead of a preventative care procedure code enable a visit to count as a well child visit when DSS or HUSKY MCOs determine how many well child visits each child has received per year. However, use of the new forms does not change DSS or MCO policy regarding reimbursement for specific codes.

2 – 14 Day Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: □ NKA ___________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: ________________ Formula (type): ____________

Developmental Screen: Age Appropriate? (e.g., rooting reflex, startle, suck & swallow) Yes ________ No ________

If suspicious, specific objective testing performed ____________________

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		
2nd Newborn PKU (>72 hrs) prenatal labs/history		

ASSESSMENT & PLAN:

IMMUNIZATIONS:

- **Was Hepatitis B given at birth?** **Yes** ________ **No** ________
- **Pt. needs immunizations?** **Yes** ________ **No** ________
- **Shot Record initiated?** **Yes** ________ **No** ________

ANTICIPATORY GUIDANCE

- □ Breast or formula, feeding frequency – amount
- □ Early dental decay
- □ Supine sleep position
- □ Injury prevention/ "babyproofing"
- □ Safety with siblings and pets
- □ Drowning prevention
- □ Car seat/auto safety
- □ **"Shaken baby syndrome"**
- □ Signs of Illness
- □ Temperature taking, When to contact doctor
- □ Emergency/911
- □ Passive smoke
- □ Parenting practices
- □ "Safe at home"
- □ Potential for abuse
- □ Postpartum adjustment
- □ Family involvement
- □ **Parent/infant attachment**
- □ **Next appointment**

REFERRALS: □ **WIC** □ **Birth to Three** □ **Specialty** □ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age

1 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐ NKA __________________	Current Medication(s)

				❑	❑
Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: ______________________ Formula (type): ______________________

Developmental Screen: Age Appropriate? (e.g., responds to sounds, responds to parent's voice, follows with eyes?) Yes ______ No ______

If suspicious, specific objective testing performed ______________________

Behavioral Screen: Age appropriate? (parental interview) ______________________ Yes ________ No ________

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS:

Was Hepatitis B given at birth? **Yes** ________ **No** ________

Shot Record initiated? **Yes** _____ **No** _____

ANTICIPATORY GUIDANCE

- ❑ **Breastfeeding/Formula exclusive**
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/"Baby-proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ **Sun safety**
- ❑ Car seat/Auto safety
- ❑ **"Shaken baby syndrome"**
- ❑ Signs of Illness
- ❑ Temp. taking, when to call Dr.
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ **Child care safety**
- ❑ **Limit TV/Video exposure**
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ **Parent/infant attachment**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth to Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age

2 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name: First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐ NKA __________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: ____________________ Formula (type): ____________________

Developmental Screen: Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?) Yes _______ No ________

If suspicious, specific objective testing performed ______________________________

Behavioral Screen: Age appropriate? (parental interview) ____________________ Yes __________ No __________

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** _____ **Delayed?** _____ **Deferred?** _______

Given today? Hep B ____ **DTaP** _____ **IPV** ______ **Hib** _____ **PCV** _____ **Other** ______________

ANTICIPATORY GUIDANCE

- ❑ Breastfeeding/Formula exclusive
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/"Baby-proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ **Sun safety**
- ❑ Car seat/Auto safety
- ❑ "Shaken baby syndrome"
- ❑ Signs of illness
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ Childcare safety
- ❑ Limit TV/Video exposure
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ Parent/Infant attachment
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age

4 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by: | Allergies: ☐ NKA ________________ | Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: ____________________ Formula (type): ____________________

Developmental Screen: Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well) Yes ________ No ______

If suspicious, specific objective testing performed ____________________

Behavioral Screen: Age appropriate? (parental interview) ____________________ Yes ________ No ______

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _____ **No** _____ **Delayed?** _____ **Deferred?** _____

Given today? Hep B ____ **DTaP** _____ **IPV** _____ **Hib** ________ **PCV** _____ **Other** ____________

ANTICIPATORY GUIDANCE

- ❑ **May introduce baby food slowly**
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/"Baby-proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ Sun safety
- ❑ Car seat/Auto safety
- ❑ "Shaken baby syndrome"
- ❑ Signs of illness
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ Child care safety
- ❑ Limit TV/Video exposure
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ **Fears and phobias**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

6 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐ NKA _______________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: _________________ Formula (type): ___________________ Solids: ___________________

Developmental Screen: Age Appropriate? (e.g., rolls over, transfers small objects, vocal imitation) Yes ________ No ________

If suspicious, specific objective testing performed ____________________

Behavioral Screen: Age appropriate? (parental interview) ______________________ Yes _______ No ________

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

SCREENINGS:

Verbal Lead Risk Assessment

Yes/ No

ASSESSMENT & PLAN:

IMMUNIZATIONS: Pt. needs immunizations? Yes ___ No _____ Delayed? _________ Deferred? ________

Given today? Hep B ______ DTaP ______ IPV ______ Hib __ PCV ______ Other ________ Influenza __________

ANTICIPATORY GUIDANCE

- ❑ **Finger foods**
- ❑ **Introduce cup use**
- ❑ **Teething**/Early dental decay
- ❑ **Dental gum care**
- ❑ Supine sleep position
- ❑ Injury prevention/ "Baby - proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ Sun safety
- ❑ Car seat/Auto safety
- ❑ "Shaken baby syndrome"
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting advice
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ Child care safety
- ❑ Limit TV/Video exposure
- ❑ Family involvement
- ❑ **Interaction with parents**
- ❑ **Parental/Sibling adjustment**
- ❑ Fears and phobias
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age

9 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: □ NKA ______________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:
Pulse:
Resp:
Fluoride checked? (if well water)

Dental Screen: Brushing teeth? Yes No Education re: Limit sugar intake/give healthy snacks? Yes No

Nutritional Screen: Breast Feeding: Formula (type): Solids:

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test **(perform if at risk)**
Ear/Hearing			
Eyes/Vision			**Blood lead test/ referral (or perform at 1 year)**
Mouth/Throat/Teeth			
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct (HRisk/WIC) ________
Heart			Urinalysis ________
Abdomen			Other:
Genitourinary			**Behavioral /Developmental Screen**
Extremities			□ Home Environment
Back/Hips			□ **General Screen** (e.g. PEDS or other tool)
Neurological			□ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _______ **No** _____ **Delayed?** ____________

Given today? **Hep B** _______ **Hib** ____ **DTap** _______ **PCV** ____ **Influenza** ______ **IPV** ____ **Other** ______

ANTICIPATORY GUIDANCE PROVIDED

- □ Finger foods/**Self-feeding**
- □ **Transition to cup**
- □ Early dental decay
- □ **Sleep practices**
- □ Injury prevention/ "Babyproofing"/ **Poison Control #**
- □ Safety with Siblings and Pets
- □ **Drowning Prevention/sun safety**
- □ **Car seat/auto safety**
- □ "Shaken baby syndrome"
- □ Emergency/911
- □ Passive Smoke
- □ **Parenting Advice**
- □ "Safe at Home"
- □ Potential for abuse
- □ Child Care Safety
- □ Limit TV/Video Exposure
- □ **Time with parents/reading**
- □ Family Involvement
- □ Interactions with Parents
- □ **Stranger Awareness**
- □ **Sibling interactions**
- □ **Parental Adjustment**
- □ **Family functioning**
- □ **Next appointment**

REFERRALS: □ **WIC** □ **Birth to Three** □ **Dental** □ **Specialty** □ **Other**

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Update 1-06 **Bold** = First asked this age.

12 Month Old Well Care Exam (EPSDT) Form

Date	Last Name: First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐ NKA ________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Temp: ____________
Pulse: ____________
Resp:

Parental Comments/Concerns:

Fluoride checked? (if well water)

Dental Screen: Daily tooth brushing? Yes No Frequency of sugar intake, & snacks low in sugar, discussed? Yes No

Nutritional Screen: Breast Feeding: _________ Formula (type):______________ Supplements: ________ Solids: ________

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test **(perform if at risk)**
Ear/Hearing			
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test/referral (if not done at 9 mos.)
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct (HRisk/WIC) ________
Heart			Urinalysis ________
Abdomen			Other:
Genitourinary			**Behavioral /Developmental Screen**
Extremities			❑ Home Environment
Back/Hips			❑ **General Screen** (e.g. PEDS or other tool)
Neurological			❑ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS **Pt. needs immunizations?** **Yes** _______ **No** _____ **Delayed?** ____ **Deferred?** _______

Given today? **Hep** _____ **Hib** ___ **IPV** ______ **PCV** _______ **Influenza** _____ **DTap** _____ **MMR** _______

ANTICIPATORY GUIDANCE PROVIDED

- ❑ **Nutrition/**Self-feeding
- ❑ Transition to cup
- ❑ **Dental caries prevention**
- ❑ Sleep practices
- ❑ "Babyproofing"/Poison Control #
- ❑ Safety with Siblings and Pets
- ❑ Drowning Prevention /sun safety
- ❑ Car seat/auto safety
- ❑ Emergency/911
- ❑ Passive Smoke
- ❑ "Safe at Home?"
- ❑ Parenting Advice
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ Limit TV/Video Exposure
- ❑ Time with parents/reading
- ❑ Stranger Awareness
- ❑ **Social interactions/ expectations**
- ❑ Sibling interactions
- ❑ Family functioning
- ❑ Parental Adjustment
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral** ❑ **Birth to Three** ❑ **Dental** ❑ **Nutritional**

❑ **Specialty** ❑ **Other** ____________ ***Date Consult Report Received:***

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

15 Month Old Well Care Exam (EPSDT) Form

Date	Last Name: First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐NKA ________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	

Fluoride checked? (if well water)

Dental Screen: Daily toothbrushing? Yes No Education re: Frequency of sugar intake/ Healthy Snacks? Yes No

Nutritional Screen: Breast/whole milk: Table foods: Supplements: Cup:

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**	**LABS ORDERED:**
Skin/Hair/Nails			Tuberculin Test ________
Ear/Hearing			**(perform if at risk)**
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test **(if not previously done)**
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct (HRisk/WIC)
Heart			Urinalysis
Abdomen			Other:
Genitourinary			**Behavioral /Developmental Screen**
Extremities			❑ Home Environment
Back/Hips			❑ **General Screen** (e.g. PEDS or other tool)
Neurological			❑ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** _____ **Delayed?** ____ **Deferred ?** ____ **Influenza** ___

Given today? **Hep B** _____ **DTaP** ____ **Hib** ____ **IPV** _____ **MMR** ___ **Varicella** _____ **PCV** _____

ANTICIPATORY GUIDANCE PROVIDED

- ❑ Nutrition/**Exercise**
- ❑ Dental caries prevention
- ❑ Sleep practices
- ❑ Injury prevention/“Child-proofing”
- ❑ Drowning Prevention /sun safety
- ❑ Car seat/auto safety
- ❑ **Fire Safety**
- ❑ Emergency/911
- ❑ Passive Smoke
- ❑ Parenting advice
- ❑ “Safe at Home?”
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ Time with parents/reading
- ❑ Limit TV/Video Exposure
- ❑ Sibling interactions
- ❑ Family functioning
- ❑ Parental Adjustment
- ❑ Social interactions/ Expectations
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral** ❑ **Birth to Three** ❑ **Dental** ❑ **Nutritional**

❑ **Specialty** ❑ **Other** ***Date Consult Report Received:***

Clinician Name (print) Clinician Signature See Additional/supervisory Note? Yes No

Update 1-06 **Bold** = First asked this age.

18 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies: ☐ NKA ________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Temp:
Pulse:
Resp:

Parental Comments/Concerns:

Fluoride checked? (if well water)

Dental Screen: Daily tooth brushing? Frequency of sugar intake, & snacks low in sugar, discussed? Yes No

Nutritional Screen: Breast/whole milk: Table foods: Supplements: Cup:

Hearing Screen: Within normal limits (ABR, OAE): Yes No **Speech:** Within normal limits? Yes No

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**	**LABS ORDERED:**
Skin/Hair/Nails			Tuberculin Test
Ear/Hearing			**(perform if at risk)**
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test **(if not previously done)**
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct (HRisk/WIC) ______
Heart			Urinalysis ______
Abdomen			Other:
Genitourinary			**Behavioral /Developmental Screen**
Extremities			❑ Home Environment
Back/Hips			❑ **General Screen** (e.g. PEDS or other tool)
Neurological			❑ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ____ **No** _____ **Delayed?** ______ **Deferred?** ______

Given today? **DTaP** ______ **Varicella** __________ **Influenza** _____ **HIB** __________ **Other** __________

ANTICIPATORY GUIDANCE PROVIDED

- ❑ Nutrition/exercise/**vit.**
- ❑ Dental caries prevention
- ❑ Sleep practices
- ❑ Injury prevention/ "Childproofing"
- ❑ Safety with Siblings and Pets
- ❑ Drowning Prevention /sun safety
- ❑ Car seat/auto safety
- ❑ Fire Safety
- ❑ **Violence/Prev.Gun Safety**
- ❑ Emergency/911
- ❑ Passive Smoke
- ❑ Parenting advice
- ❑ "Safe at Home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ Time with parents/reading
- ❑ Limit TV/Video Exposure
- ❑ Sibling interactions
- ❑ Family functioning
- ❑ Social interactions/ Expectations
- ❑ **Limit Setting**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral** ❑ **Birth to Three** ❑ **Dental** ❑ **Nutritional**

❑ **Speech** ❑ **Specialty** ❑ **Other** ***Date Consult Report Received:***

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

24 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt

Accompanied by:	Allergies: ☐ NKA ________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (If well water)

Dental Screen: Routine: Urgent: Parent advised: Brushing teeth? Yes No

Nutritional Screen: Adequate ____________ Inadequate ________ Supplements: ____________

Hearing Screen: Within normal limits *(ABR, OAE):* Yes No **Speech:** Within normal limits? Yes No

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**	**LABS ORDERED:**
Skin/Hair/Nails			Tuberculin Test
Ear/Hearing			**(perform if at risk)**
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test referral
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct (HRisk/WIC) ____________
Heart			Urinalysis ____________
Abdomen			Other:
Genitourinary			**Behavioral /Developmental Screen**
Extremities			❑ Home Environment
Back/Hips			❑ **General Screen** (e.g. PEDS or other tool)
Neurological			❑ Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _____ **No** ______ **Delayed?** _______ **Deferred?** __________

Given today? _____ **Hep B** _______ **Varicella** _______ **Influenza** ________ **HIB** _______ **Other** _______

ANTICIPATORY GUIDANCE PROVIDED

- ❑ Nutrition/exercise/vitamins
- ❑ Dental caries prevention/ **dental care**
- ❑ Discontinue Pacifier Use
- ❑ Injury prevention/ "Childproofing"
- ❑ **Poisonous Plant Awareness**
- ❑ Safety with Siblings and Pets
- ❑ Drowning Prevention /sun safety
- ❑ Car seat/auto safety
- ❑ Violence Prevention/gun safety
- ❑ Fire Safety/**Burns**
- ❑ Emergency/911
- ❑ Passive Smoke
- ❑ Parenting advice
- ❑ "Safe at Home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ **Toilet training**
- ❑ Read to child
- ❑ Limit TV/Video exposure
- ❑ Family involvement
- ❑ **Fears and Phobias**
- ❑ **Peer Companionship**
- ❑ **Self control**
- ❑ **Sexual self-awareness**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral** ❑ **Birth to Three** ❑ **Dental** ❑ **Nutritional**

❑ **Speech** ❑ **Specialty** ❑ **Other** ***Date Consult Report Received:***

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Bold = First asked this age.

3 Year Old Well Care EPSDT Tracking Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt
Accompanied by:		Allergies: ☐ NKA ________________		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam (if able)
OD ________
OS ________
OU ________
Corrected / uncorrected

Temp:
Pulse:
Resp:
BP :
Fluoride checked? (If well water)

Dental Screen: Next appt: Routine Urgent
Date of Last exam/referral:
Parent advised Brushing child's teeth?

Nutritional Screen: Adequate Inadequate Supplements:
Physical Activity:

Hearing Screen: Within normal limits? (Audiometry) Yes No **Speech:** Within Normal Limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
Tuberculin Test **(perform if at risk)**
Verbal Lead Risk Assessment
Blood lead test **(If not done at age 24 months)** ________

Additional Labs Ordered:
Hgb/Hct (HRisk/WIC) ________
Urinalysis ________
Other:

Behavioral /Developmental Screen
- ❑ Home Environment
- ☐**General Screen** (e.g. PEDS or other tool)
- ❑ Activities (risk level)
- ❑ School Readiness

ASSESSMENT & PLAN: (Confidential Documentation attached)

IMMUNIZATIONS **Given Today?** ________ **Hep B** ________ **Varicella** ________ **PCV** ________
Hep A ________ **Influenza** ________ **Other** ________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Nutrition/ exercise/ vitamins
- ❑ Dental care
- ❑ Injury Prevention/"Childproofing
- ❑ Poisonous Plant Awareness
- ❑ Safety with Siblings and Pets
- ❑ Drowning Prevention/Sun Safety
- ❑ Car Seat /Auto safely
- ❑ **Sport bike/helmet use**
- ❑ Violence Prev./Gun Safety
- ❑ **Pedestrian/Traffic Safety**
- ❑ Emergency/911
- ❑ Passive Smoke
- ❑ Parenting advice
- ❑ "Safe at home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ Reading/ Preschool
- ❑ Toilet training
- ❑ Limit TV/Video/ Exposure
- ❑ **Discourage Thumbsucking**
- ❑ Family involvement
- ❑ Limits/Consequences
- ❑ Social Interactions/ Expectations
- ❑ Sexual Self-awareness
- ❑ Peer Companionship
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral/ Developmental** ❑ **Dental** ❑ **Nutritional**
❑ **Speech** ❑ **Other** ________

Date Consult Report Received:

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

Update 1-06 **Bold** = First asked this age.

4 Year Old Well Care Exam (EPSDT) Form

Date	Last Name: First Name:	Date of Birth	Age	I gpf gt

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam
OD _________
OS _________
OU _________
Corrected / uncorrected

Temp: _______
Pulse: _______
Resp: _______
BP
Fluoride checked? (If well water)

Dental Screen: Date of last exam: ________ Next appt: _______ Routine _______ Urgent _____ Parent advised

Nutritional Screen: Adequate ______ Inadequate ______ Supplements: __________ **Physical Activity:** ____________

Hearing Screen: Within normal limits? (Audiometry) Yes No **Speech:** Within Normal Limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:

Tuberculin Test ________
(perform if at risk)

Verbal Lead Risk Assessment ________

Blood lead test **(if not done since age 1)** ________

Additional Labs Ordered:
Hgb/Hct (HRisk/WIC) ________
Urinalysis ________
Other:

Behavioral /Developmental Screen
- ❑ Home Environment
- ❑ **General Screen** (e.g. PEDS or other tool)
- ❑ Activities (risk level)
- ❑ School readiness

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS Given Today: Hep B _____ **Td** _____ **MMR** ________ **IPV** _________

DTaP ______ **Influenza** _______ **Varicella** _______ **Hep A** _______ **Other** ____________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental care
- ❑ Drowning/Sun Safety
- ❑ Car Seat/Auto safely
- ❑ Sport bike/Helmet use
- ❑ Sports/Injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Fire Safety
- ❑ Passive Smoke
- ❑ "Safe at home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ **Toileting Habits**
- ❑ Reading **to child/ Pre-school**
- ❑ **Limit TV/Internet Use**
- ❑ **Social Interaction**
- ❑ **Family functioning**
- ❑ **Self Control**
- ❑ Parenting advice
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral/ Developmental** ❑ **Dental** ❑ **Nutritional** ❑ **Speech**
❑ **Specialty** ❑ **Other**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes No

Update 1-06 **Bold** = *First asked this age range*

5 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam
OD ________
OS ________
OU ________
Corrected / uncorrected

Temp: ________
Pulse: ________
Resp: ________
BP
Fluoride checked? (If well water)

Dental Screen: Date of last exam: _________ Next appt: _______ Routine _____ Urgent _____ Parent advised____

Nutritional Screen: Adequate ______ Inadequate ________ Supplements: ____________ **Physical Activity:** ____________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ____ No ______

Hearing Screen: Within normal limits? (Audiometry) Yes No **Speech:** Within Normal Limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
- Tuberculin Test ________ **(perform if at risk)**
- Verbal Lead Risk Assessment ________
- Blood lead test **(if not done since age 1)**

Additional Labs Ordered:
- Hgb/Hct (HRisk/WIC) ________
- Urinalysis ________
- Other:

Behavioral /Developmental Screen
- ❑ Home Environment
- ❑ **General Screen** (e.g. PEDS or other tool)
- ❑ Activities (risk level)

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS Given Today: **PCV** ____ **Hep B** ____ **DTaP** ____ **IPV** ___________
MMR _____ **Varicella** ______ **Hep A** _______ **Influenza** _______ **Other** _____________________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental care
- ❑ Drowning/Sun Safety
- ❑ Car Seat /Auto safely
- ❑ Sport bike/Helmet use
- ❑ Sports/injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Fire Safety
- ❑ Passive Smoke
- ❑ "Safe at home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ **Toileting Habits**
- ❑ Reading to child**/School readiness**
- ❑ **Limit TV/Video/Internet Use**
- ❑ Social Interaction
- ❑ Family Dynamics
- ❑ Self Control
- ❑ Parenting advice
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **Speech** ❑ **Specialty:**

Date Consult Report Received:

See Additional/Supervisory Note? Yes No

Clinician Name (print) Clinician Signature

Update 1-06 **Bold** = *First asked this age range*

6 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam (if needed @)
OD ________
OS ________
OU ________
Corrected / uncorrected

Temp: ________
Pulse: ________
Resp: ________
BP
Fluoride checked? (If well water)

Dental Screen: Date of last exam: __________ Next appt:_______ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate ________ Inadequate ____ Supplements: __________ **Physical Activity:** __________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ______ No ______

Hearing Screen: Within normal limits? Audiometry (@ - if not done at school) Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test ________
Ear/Hearing			**(perform if at risk)**
Eyes/Vision			Verbal Lead Risk Assessment ________
Mouth/Throat/Teeth			Blood lead test **(perform once, at age up to 72 months)**
Nose/Head/Neck			**Additional Labs Ordered:**
Lungs			Hgb/Hct ________
Heart			Urinalysis ________
Abdomen			Other:
Genitourinary			❑ Behavioral/Developmental Screen **(or substitute GAPS or other tool)**:
Extremities			❑ Home Environment ❑ Activities (risk level)
Back/Hips			❑ **General Screen** (e.g. PEDS or other)
Neurological			❑ School Attendance ❑ School Performance ❑ Social Interactions

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS Given Today: **Hep B** _____ **DTaP** _____ **IPV** ___________
MMR _____ **Varicella** ______ **Hep A** _______ **Influenza** _______ **Other** ___________

ANTICIPATORY GUIDANCE PROVIDED

- ❑ Good nutrition/Exercise
- ❑ Dental care
- ❑ Drowning/Sun Safety
- ❑ Car Seat or Seat Belt/Auto safety
- ❑ Sport bike/Helmet use
- ❑ Sports/Injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Fire Safety
- ❑ Passive Smoke
- ❑ "Safe at home?"
- ❑ Potential for abuse
- ❑ Child Care Safety
- ❑ Toileting Habits
- ❑ Reading **with child**
- ❑ Limit TV/Video/Internet Use
- ❑ Social Interaction
- ❑ **Age Appropriate Behavior**
- ❑ Family Functioning
- ❑ Self Control
- ❑ Parenting advice
- ❑ **Next appointment**

REFERRALS: ❑ **Behavioral/Developmental** ❑ **Dental** ❑ **Nutritional** ❑ **Specialty:** ❑ **Other**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes No

Update 1-06 **Bold** = *First asked this age range*

7-8 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt
"					

Accompanied by:	Allergies:NKA☐ ____________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam (if needed-@)
OD ______________
OS ______________
OU
Corrected / uncorrected

Temp: __________
Pulse: __________
Resp: __________
BP
Fluoride checked? (If well water)

Dental Screen: Date of last exam: ________ Next appt: _______ Routine _______ Urgent _____ Parent advised ___

Nutritional Screen: Adequate ______ Inadequate ______ Supplements: ______________ **Healthy Food Choices** *Yes /No*

Hearing Screen: Within normal limits? (@ - if not done at school) Yes No **Physical Activity:**

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
Tuberculin Test ________
(perform if at risk)
Hgb/Hct __________
Urinalysis __________
Lipid profile
(perform if at risk) __________
Other Tests: __________

Behavioral/Developmental Screen
❑ Home Environment
❑ Activities (risk level)
❑ **General Screen** (e.g. PEDS or other)
❑ School Attendance
❑ School Performance
❑ Social Interactions

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS **Given Today:** **Hep B** ______ **PCV** __________ **Varicella** __________
Hep A __________ **Influenza** ________ **Other** __________

ANTICIPATORY GUIDANCE PROVIDED
❑ Good nutrition/Exercise
❑ Dental**/Flossing/Self care**
❑ Drowning/Sun Safety
❑ Seat Belt/Auto safety
❑ Sport bike/Helmet use
❑ Sports/Injury prevention
❑ Violence prevention/Gun safety
❑ Passive Smoke
❑ "Safe at home?"
❑ **Afterschool/**Child Care Issues
❑ **Sex Education**
❑ Limit TV/Video/Internet Use
❑ Tobacco/Alcohol/Drugs/ Inhalants
❑ Social Interaction
❑ Family Functioning
❑ Self Control
❑ **Depression/Anxiety**
❑ Conflict resolution skills
❑ Parenting advice
❑ **Next appointment**

REFERRALS: ❑ **Behavioral/Developmental** ❑ **Dental** ❑ **Nutritional** ❑ **Specialty:** ❑ **Other**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes No

Update 1-06

Bold = *First asked this age range*

9-10 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt

Accompanied by:	Allergies:NKA☐___________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam
OD _______
OS _______
OU _______
Corrected / uncorrected

Temp: _______
Pulse: _______
Resp: _______
BP
Fluoride checked? (If well water)

Dental Screen: Date of last exam: _______ Next appt: _______ Routine _______ Urgent _______ Parent advised

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: __________ **Physical Activity:** __________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ___ No _____

Hearing Screen: Within normal limits? Yes No **Adequate Sleep** Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary/Breast		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
- Tuberculin Test ________ **(perform if at risk)**
- Hgb/Hct ________
- Urinalysis ________
- Lipid profile **(perform if at risk)** ________
- **Other Tests:** ________ ________

Behavioral Screen (or substitute GAPS or other tool**):**
- ❑ Home Environment
- ❑ Educational Goals ❑ Activities (risk level)
- ❑ Drugs/Alcohol/Inhalants
- ❑ Depression/Anxiety

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS Given Today: Hep B _______ **Td** _______ **MMR** ______
Varicella _________ **Hep A** ________ **Influenza** ______________ **Other** __________

ANTICIPATORY GUIDANCE PROVIDED

- ❑ Good nutrition/Exercise
- ❑ Dental/Flossing/Self care
- ❑ Drowning/Sun Safety
- ❑ Seat Belt/Auto safely
- ❑ Sport bike/helmet use
- ❑ Sports/Injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Passive Smoke
- ❑ "Safe at home?"
- ❑ Afterschool/Child Care Issues
- ❑ Sex Education
- ❑ **Educational goals/Activities**
- ❑ Limit TV/Video/Internet Use
- ❑ Tobacco/alcohol/drugs/inhalants
- ❑ **Peer refusal skills/Gangs**
- ❑ Social Interaction
- ❑ Family Functioning
- ❑ Self Control
- ❑ Depression/Anxiety
- ❑ Conflict resolution skills
- ❑ Parenting advice
- ❑ **Next appointment**

REFERRALS: ❑ **Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **OB/GYN** ❑ **Specialty:**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes No

Update 1-06 **Bold** = *First asked this age range*

11, 12 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt "

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam at Age 12
OD ___________
OS ___________
OU ___________
Corrected / uncorrected

Temp: ___________
Pulse: ___________
Resp: ___________
BP

Fluoride checked? (If well water)

Dental Screen: Date of last exam: ___________ Next appt: ________ Routine _____ Urgent _____ Parent advised

Nutritional Screen: Adequate ______ Inadequate _____ Supplements: ___________ **Physical Activity:** ___________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ___ No ______

Hearing Screen: Within normal limits? Yes No **Adequate Sleep** Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary/Breast		
Pelvic Exam/STD Screening (if appropriate)		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
- Tuberculin Test ________ **(perform if at risk)**
- Hgb/Hct ________
- Urinalysis ________
- Lipid profile **(perform if at risk)** ________
- **Other Tests:** ________ ________

Behavioral Screen (or substitute GAPS or other tool)**:**
- ❑ Home Environment
- ❑ Activities (risk level)
- ❑ Educational Goals
- ❑ Depression/Suicide
- ❑ Sexual Activity
- ❑ Drugs/Alcohol

ASSESSMENT & PLAN: (Confidential Documentation attached ☐)

IMMUNIZATIONS Given Today: **Hep B** _______ **Td** ______ **MMR** _________ **Varicella** _________ **Hep A** ________ **Influenza** ___________ **Other** ____________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental/Flossing/Self care
- ❑ Drowning/Sun Safety
- ❑ Seat Belt/Auto safely
- ❑ Sport bike/Helmet use
- ❑ Sports/injury prevention
- ❑ Passive Smoke
- ❑ "Violence prevention/Gun safety
- ❑ Safe at home?"
- ❑ Sex Education/**Counseling**
- ❑ Educational goals/Activities
- ❑ Limit TV/Internet Use
- ❑ Tobacco/alcohol/drugs/inhalants
- ❑ Peer refusal skills/Gangs
- ❑ Social Interaction
- ❑ Family Involvement
- ❑ Self Control
- ❑ Depression/Anxiety
- ❑ Conflict resolution skills
- ❑ Parenting advice)
- ❑ **Next appointment**

REFERRALS: ❑ **Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **OB/GYN** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

See Additional/Supervisory Note? Yes No

Clinician Name (print) Clinician Signature

Update 1-06

Bold = *First asked this age range*

13, 14 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	I gpf gt

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Exam (if needed)
OD ____________
OS ____________
OU
Corrected / uncorrected

Temp: ______
Pulse: ______
Resp: ______
BP

Dental Screen: Date of last exam: _______ Next appt: _______ Routine _______ Urgent _______ Parent advised _______

Nutritional Screen: Adequate ______ Inadequate ______ Supplements: __________ **Physical Activity:** __________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes _______ No ___

Hearing Screen: Within normal limits? Yes No **Adequate Sleep** Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary/Breast		
Pelvic Exam/STD Screening (if appropriate)		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
Tuberculin Test ________
(perform if at risk)
Hgb/Hct ________
Urinalysis ________
Lipid profile
(perform if at risk) ________
Other Tests: ________

Behavioral Screen (or substitute GAPS or other tool**):**
- ❑ Home Environment
- ❑ Educational Goals
- ❑ Activities (risk level)
- ❑ Drugs/Alcohol
- ❑ Depression/Suicide
- ❑ Sexual Activity

ASSESSMENT & PLAN: (Confidential Documentation attached☐)

IMMUNIZATIONS Given Today: **Hep B** _____ **Td** _______ **MMR** _________

Varicella _______ **Hep A** ________ **Influenza** ______ **Other** ____________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental/Flossing/Self care
- ❑ Drowning/Sun Safety
- ❑ Seat Belt/Driving safety
- ❑ Sport bike/Helmet use
- ❑ Sports/injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Parenting advice
- ❑ "Safe at home?"
- ❑ Sex Education/Counseling
- ❑ Educational goals/activities
- ❑ Limit TV/Internet Use
- ❑ Tobacco/alcohol/drugs/inhalants
- ❑ Peer refusal skills/Gangs
- ❑ Social Interaction
- ❑ Family Functioning
- ❑ Self Control
- ❑ Conflict resolution skills
- ❑ Depression/anxiety
- ❑ **Next appointment**

REFERRALS: ❑ **Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **OB/GYN** ❑ **Specialty:**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print)	Clinician Signature	Yes	No

Update 1-06

Bold = *First asked this age range*

15, 16, 17 Year Old Well Care Exam (EPSDT) Form

Date	Last Name: First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies:NKA☐___________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam-age 15
OD ____________
OS ____________
OU ____________
Corrected / uncorrected

Temp: ________
Pulse: ________
Resp: ________
BP

Dental Screen: Date of last exam: _______ Next appt: _____ Routine ________ Urgent ________ Parent advised ________

Nutritional Screen: Adequate ______ Inadequate ______ Supplements: ____________ **Physical Activity:** ____________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions, future plans) Yes ___ No _____

Hearing Screen: Within normal limits? Yes No **Adequate Sleep** Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary/Breast		
Pelvic Exam/STD Screening (if appropriate)		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
- Tuberculin Test ________ **(perform if at risk)**
- Hgb/Hct ________
- Urinalysis ________
- Lipid profile **(perform if at risk)**
- **Other Tests:** ________ ________

Behavioral Screen (or substitute GAPS or other tool**):**
- ❑ Home Environment
- ❑ Education and Work Goals/ Future Plans
- ❑ Activities (risk level)
- ❑ Drugs/Alcohol
- ❑ Depression/Suicide
- ❑ Sexual Activity

ASSESSMENT & PLAN: (Confidential Documentation attached☐)

IMMUNIZATIONS Given Today: **Hep B** _______ **Td** _______ **MMR** __________
Varicella _____ **Hep A** ________ **Influenza** ______ **Other** ____________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental/Flossing/Self care
- ❑ Drowning/Sun Safety
- ❑ Seat Belt/Driving safety
- ❑ Sport bike/Helmet use
- ❑ Sports/injury prevention
- ❑ Violence prev./Gun safety
- ❑ Parenting advice
- ❑ "Safe at home?"
- ❑ Sex Education/ Counseling
- ❑ Breast/Testicular self exam
- ❑ Educational goals/activities
- ❑ Limit TV/Internet Use
- ❑ Tobacco/Alcohol/Drugs/Inhalants
- ❑ Peer refusal skills/Gangs
- ❑ Social Interaction
- ❑ Family Functioning
- ❑ Self Control
- ❑ Depression/Anxiety
- ❑ Conflict resolution skills
- ❑ **Transition Planning (age 16 on)**
- ❑ **Next appointment**

REFERRALS: ❑ **Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **OB/GYN** ❑ **Specialty:** ❑ **WIC**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes No

Update 1-06 **Bold** = *First asked this age range*

18, 19, 20 Year Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Gender

Accompanied by:	Allergies:NKA☐____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam-age 18
OD ____________
OS ____________
OU ____________
Corrected / uncorrected

Temp: ________
Pulse: ________
Resp: ________
BP ________

Dental Screen: Date of last exam: _______ Next appt: ________ Routine ________ Urgent __________ Parent advised ________

Nutritional Screen: Adequate ________ Inadequate __________ Supplements: ___________ **Physical Activity**: __________

Developmental Screen: Age Appropriate? (School attendance, school performance, social interactions, future plans) Yes ____ No ______

Hearing Screen: Within normal limits? Yes No **Adequate Sleep** Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Lungs		
Heart		
Abdomen		
Genitourinary/Breast		
Pelvic Exam/STD Screening		
Extremities		
Back/Hips		
Neurological		

LABS ORDERED:
- Tuberculin Test ________ **(perform if at risk)**
- Hgb/Hct ________
- Urinalysis ________
- Lipid profile **(perform if at risk)** ________
- **Other Tests:** ________ ________

Behavioral Screen (or substitute GAPS or other tool)**:**
- ❑ Home Environment
- ❑ Education and Work Goals/Future Plans
- ❑ Activities (risk)
- ❑ Drugs/Alcohol
- ❑ Depression/Suicide
- ❑ Sexual Activity

ASSESSMENT & PLAN: (Confidential Documentation attached☐)

IMMUNIZATIONS Given Today: **Hep B** ________ **Td** _______ **MMR** ________
Varicella ___________ **Hep A** _________ **Influenza** ___________ **Other** ______________

ANTICIPATORY GUIDANCE PROVIDED
- ❑ Good nutrition/Exercise
- ❑ Dental/Flossing/Self care
- ❑ Drowning/Sun Safety
- ❑ Seat Belt/Driving safety
- ❑ Sport bike/Helmet use
- ❑ Sports/Injury prevention
- ❑ Violence prevention/Gun safety
- ❑ Parenting advice
- ❑ "Safe at home?"
- ❑ Sex Education/Counseling
- ❑ Breast/Testicular self exam
- ❑ Educational goals/Activities
- ❑ Limit TV/Internet Use
- ❑ Tobacco/Alcohol/Drugs/ Inhalants
- ❑ Peer refusal skills
- ❑ Social Interaction
- ❑ Family Functioning
- ❑ Self Control
- ❑ Depression/anxiety
- ❑ **Transition to Internist/ Family Practice/GP**

REFERRALS: ❑**Behavioral** ❑ **Dental** ❑ **Nutritional** ❑ **OB/GYN** ❑ **Specialty:** ❑ **WIC**

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print)	Clinician Signature	Yes	No

Bold = *First asked this age range*

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	2-4 DAYS	1 MONTH	2 MONTHS
NUTRITION and EXERCISE	Breast or formula Feeding frequency - amount	**Breastfeeding/Formula exclusive**	Breastfeeding/Formula exclusive
DENTAL HEALTH	Early dental decay	Early dental decay	Early dental decay
ACCIDENT/INJURY PREVENTION	Supine sleeping position Injury prevention/ "Babyproofing" Safety with siblings and pets Drowning prevention Car seat/Auto safety "Shaken baby syndrome"	Supine sleeping position Injury prevention/ "Babyproofing" Safety with siblings and pets Drowning prevention/ **Sun safety** Car seat/Auto safety "Shaken baby syndrome"	Supine sleeping position Injury prevention/ "Babyproofing" Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety "Shaken baby syndrome"
HEALTH AWARENESS/SAFETY HABITS	Signs of Illness Temperature taking, when to contact doctor, Emergency/911 Passive smoke Parenting practices "Safe at home" Potential for abuse	Signs of Illness Temperature taking, when to contact doctor Emergency/911 Passive smoke Parenting practices "Safe at home" Potential for abuse **Child care safety** **Limit TV/Video exposure**	Signs of illness Emergency/911 Passive smoke Parenting practices "Safe at home" Potential for abuse Child care safety Limit TV/Video exposure
PSYCHOSOCIAL ISSUES	Postpartum adjustment Family involvement Parent/Infant attachment	Postpartum adjustment Family involvement Parent/Infant attachment	Postpartum adjustment Family involvement Parent/Infant attachment
FOR ADDITIONAL INFORMATION	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	FOUR MONTHS	SIX MONTHS	NINE MONTHS	TWELVE MONTHS
NUTRITION and EXERCISE	**May introduce baby food slowly**	**Finger foods** **Introduce cup use**	Finger Foods/**Self-feeding** **Transition to cup**	**Nutrition**/Self-feeding Transition to cup
DENTAL HEALTH	Early dental decay	**Teething** / Early dental decay	Early dental decay	**Dental caries prevention**
ACCIDENT/INJURY PREVENTION	Supine sleeping position Injury prevention/ "Babyproofing"/ Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety "Shaken baby syndrome"	Supine sleeping position Injury prevention/ "Babyproofing" Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety "Shaken baby syndrome"	**Sleep practices** Injury prevention/ "Babyproofing"/ **Poison control no.** Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety "Shaken baby syndrome"	Sleep practices "Babyproofing"/ Poison Control no. Safety with siblings and pets Drowning/ Sun safety Car seat/Auto safety
HEALTH AWARENESS/ SAFETY HABITS	Signs of Illness Emergency/911 Passive smoke Parenting practices "Safe at home" Potential for abuse Child care safety Limit TV/Video exposure	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Limit TV/Video exposure	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Limit TV/Video exposure **Time with parents/Reading**	Emergency/911 Passive smoke "Safe at home" Parenting advice Potential for abuse Child care safety Limit TV/Video exposure Time with parents/Reading
PSYCHOSOCIAL ISSUES	Postpartum adjustment Family involvement Parent/Infant attachment **Fears and phobias**	Family involvement **Interactions with parents** **Parental/Sibling adjustment** Fears and phobias	Family involvement Interactions with parents **Stranger awareness** **Sibling interactions** **Parental adjustment** **Family functioning**	Stranger Awareness **Social Interactions/ Expectations** Sibling interactions Family functioning Parental adjustment
FOR ADDITIONAL INFORMATION	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	FIFTEEN MONTHS	EIGHTEEN MONTHS	TWENTY FOUR MONTHS
NUTRITION and EXERCISE	Nutrition/**Exercise**	Nutrition/Exercise/Vitamins	Nutrition/Exercise/Vitamins
DENTAL HEALTH	Dental caries prevention	Dental caries prevention	Dental caries prevention/**Dental care** **Discontinue pacifier use**
ACCIDENT/INJURY PREVENTION	Sleep practices Injury prevention/ "Childproofing" Drowning prevention/ Sun safety Car seat/auto safety **Fire safety**	Sleep practices Injury prevention/ "Childproofing" Safety with siblings and pets Drowning/Sun safety Car seat/Auto safety Fire Safety **Violence prevention/** **Gun safety**	Injury prevention/ "Childproofing" Poisonous plant awareness Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety Fire safety/**Burns** Violence prevention/ Gun safety
HEALTH AWARENESS/SAFETY HABITS	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Time with parents/ Reading Limit TV/Video exposure	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Time with parents/Reading Limit TV/Video exposure	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety **Toilet training** Read to child Limit TV/Video exposure
PSYCHOSOCIAL ISSUES	Sibling interactions Family functioning Parental adjustment Social interactions/ Expectations	Sibling interactions Family functioning Social interactions/ Expectations **Limit setting**	Family involvement **Fears and phobias** **Peer companionship** **Self control** **Sexual self-awareness**
FOR ADDITIONAL INFORMATION	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	THREE YEARS	FOUR YEARS	FIVE YEARS	SIX YEARS
NUTRITION and EXERCISE	Nutrition/ Exercise/Vitamins	**Good** nutrition/Exercise	Good nutrition/Exercise	Good nutrition/Exercise
DENTAL HEALTH	Dental care	Dental care	Dental care	Dental care
ACCIDENT/INJURY PREVENTION	Injury prevention/ "Childproofing" Poisonous plant awareness Safety with siblings and pets Drowning prevention/ Sun safety Car seat/Auto safety Sport/Bike helmet use Violence prevention/Gun safety Pedestrian/Traffic safety	Drowning/ Sun safety Car seat/Auto safety Sport bike/Helmet use Sports/ Injury prevention Violence prevention/ Gun safety Fire safety	Drowning/Sun safety Car seat/Auto safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/ Gun safety Fire safety	Drowning/Sun safety Car seat **or seat belt**/ Auto safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/ Gun safety Fire safety
HEALTH AWARENESS/ SAFETY HABITS	Emergency/911 Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety **Reading/Preschool** Toilet training Limit TV/Video Exposure **Discourage Thumb sucking**	Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety **Toileting habits** Reading **to child**/Preschool **Limit TV/Internet use**	Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Toileting habits Reading to child/ **School readiness** **Limit TV/Video/** **Internet use**	Passive smoke Parenting advice "Safe at home" Potential for abuse Child care safety Toileting habits Reading **with child** Limit TV/Video/ Internet use
PSYCHOSOCIAL ISSUES	Family involvement **Limits/Consequences** **Social interactions/** **Expectations** Sexual self-awareness Peer companionship	**Social interaction** **Family functioning** **Self control**	Social interaction **Family dynamics** Self control	Social interaction **Age-appropriate behavior** Family **functioning** Self control
FOR ADDITIONAL INFORMATION	Literature on Child Develop-ment **Next Appointment**	Literature on Child Develop-ment **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child Develop-ment **Next Appointment**

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	7-8 YEARS	9-10 YEARS	11,12 YEARS
NUTRITION and EXERCISE	Good nutrition/Exercise	**Good nutrition**/Exercise	Good nutrition/Exercise
DENTAL HEALTH	Dental care/**Flossing**/**Self care**	Dental/ Flossing/Self care	Dental/ Flossing/Self care
ACCIDENT/INJURY PREVENTION	Drowning/Sun safety Seat belt/Auto safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/Gun safety	Drowning/Sun safety Seat belt/Auto safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/Gun safety	Drowning/Sun safety Seat belt/Auto safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/Gun safety
HEALTH AWARENESS/ SAFETY HABITS	Passive smoke Parenting advice "Safe at home" Potential for abuse **Afterschool**/Child care issues **Sex education** Limit TV/Video/Internet use **Tobacco/Alcohol/Drugs/ Inhalants**	Passive smoke Parenting advice "Safe at home" Potential for abuse Afterschool/Child care issues Sex education **Education goals/Activities** Limit TV/Video/Internet use Tobacco/Alcohol/Drugs/Inhalants **Peer refusal skills/Gangs**	Passive smoke Parenting advice "Safe at home" Sexual education/**Counseling** Education goals/Activities Limit TV/Internet use Tobacco/Alcohol/Drugs/Inhalants Peer refusal skills/Gangs
PSYCHOSOCIAL ISSUES	Social interaction Age-appropriate behavior Family functioning Self control **Depression/Anxiety** **Conflict resolution skills**	Social interaction Family functioning Self control Depression/Anxiety Conflict resolution skills	Social interaction Family functioning Self control Depression/Anxiety Conflict resolution skills
FOR ADDITIONAL INFORMATION	Literature on Child Development **Next Appointment**	Literature on Child Development **Next Appointment**	Literature on Child/Adolescent Development **Next Appointment**

RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

AGES	13,14 YEARS	15,16,17 YEARS	18,19,20 YEARS
NUTRITION and EXERCISE	Good nutrition/Exercise	Good nutrition/Exercise	Good Nutrition/Exercise
DENTAL HEALTH	Dental/ Flossing/Self care	Dental/ Flossing/Self care	Dental/ Flossing/Self care
ACCIDENT/INJURY PREVENTION	Drowning/Sun safety Seat belt/**Driving** safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/Gun safety	Drowning/Sun safety Seat belt/Driving safety Sport bike/Helmet use Sports/Injury prevention Violence prevention/Gun safety	Drowning/Sun safety Seat belt/Driving safety Sport bike/Helmet use Sports/Injury prevention Violence Prevention/Gun safety
HEALTH AWARENESS/ SAFETY HABITS	Parenting advice "Safe at home" Sexual education/Counseling Education goals/Activities Limit TV/Internet use Tobacco/Alcohol/Drugs/Inhalants Peer refusal skills/Gangs	Parenting advice "Safe at home" Sexual Education/Counseling **Breast/Testicular Self Exam** Education goals/Activities Limit TV/Internet Use Tobacco/Alcohol/Drugs/Inhalants Peer refusal skills/Gangs	Parenting advice "Safe at home" Sex Education/Counseling Breast/Testicular self exam Education goals/Activities Limit TV/Internet Use Tobacco/Alcohol/Drugs/Inhalants Peer refusal skills
PSYCHOSOCIAL ISSUES	Social interaction Family functioning Self control Depression/Anxiety Conflict resolution skills	Social interaction Family functioning Self control Depression/Anxiety Conflict resolution skills ***Special Needs:* Transition planning (start at age 16)**	Social interaction Family functioning Self control Depression/Anxiety *Special Needs:* Transition Planning
FOR ADDITIONAL INFORMATION	Literature on Child/Adolescent Development **Next Appointment**	Literature on Child/Adolescent Development **Next Appointment**	**Next Appointment** **Transition to Internist/ Family Practice/GP**