Screen Date _____

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

11, 12 and 13 Year Form

Name_____ DOB_____ Age_____ Sex: M F Wt_____ Ht_____ BMI_____ BP_____ Pulse_____ Temp_____

Allergies: ◻ NKDA _____ Current Meds: ◻ None_____

Accompanied by: ◻ Parent ◻ Grandparent ◻ Foster parent ◻ Foster organization ◻ Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
◻ **UTD** ◻ Given, see vaccine record

◻ **Vision Acuity Screen** *(Obj @ 12 yrs)* R _____ L _____
Wears glasses ◻ Yes ◻ No

◻ **Hearing Screen** *as indicated by risk screen:* 20 db@
R ear:____ 500HZ R ear:____ 1000HZ ____ 2000HZ _____ 4000HZ
L ear:____ 500HZ L ear:____ 1000HZ ____ 2000HZ _____ 4000HZ
Wears hearing aids ◻ Yes ◻ No

Oral Health Screen
Date of last dental visit_____
◻ Current oral health problems:

◻ **Developmental Surveillance**

Referrals: ◻ Behavioral/Mental Health ◻ Dentist ◻ Vision
◻ Hearing ◻ FP ◻ CSHCN **1-800-642-9704**

Provider signature required for validation
◻ **Risk indicators reviewed/screen complete**

_____
Please Print Name of Facility or Clinic

_____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: ◻ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Social Emotional Health/Interpersonal Trauma

Social/Family: ✓ ***Check those that apply***
Family situation: ◻ No change
Parent(s)/Caretaker(s) working outside home? ◻ Yes ◻ No
Child care? ◻ Yes ◻ No ◻ NA
Have you lived anywhere but with your parents/caregivers?
◻ Yes ◻ No _____
Sibling(s) in the home? ◻ Yes ◻ No _____
Do you get along with other family members? ◻ Yes ◻ No
If you could, how would you change your life?
home?_____
family?_____

Traumatic Stress Reactions[1]: ✓ ***Check one for each question***
Feelings over the past 2 weeks:
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? ◻ Not at all
◻ A little bit (1) ◻ Moderately (2) ◻ Quite a bit (3)
◻ Extremely (4)
Feeling very upset when something reminded you of a stressful experience from the past? ◻ Not at all
◻ A little bit (1) ◻ Moderately (2) ◻ Quite a bit (3)
◻ Extremely (4)

Depression Screen: ✓ ***Check one for each question***
If Positive see Periodicity Schedule
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: ◻ Not at all
◻ Several days ◻ More than ½ the days ◻ Nearly every day
Feeling down, depressed, or hopeless: ◻ Not at all
◻ Several days ◻ More than ½ the days ◻ Nearly every day

Psychosocial/Behavior Screen: ✓ ***Check those that apply***
Fun activities: _____
Friend(s): ◻ Yes ◻ No
◻ Thoughts/plans to harm ◻ Self ◻ Others ◻ Animals ◻ NA
◻ Experienced an emotional loss

Risk indicators: ✓ ***Check those that apply***
◻ None identified ◻ Poor self image
◻ Lack of physical activity ◻ Weight or height concerns
◻ Tobacco use: ◻ Cigarettes/# per day_____
◻ E-Cigs ◻ Chew ◻ Passive Smoking Risk
◻ *Alcohol use_____ ◻ *Other drugs_____
If positive see Periodicity Schedule
◻ Access to weapon(s) ◻ Has a weapon(s)
◻ Witnessed violence ◻ Threatened with violence
Has anyone ever hit, choked, kicked or hurt you? ◻ Yes ◻ No
Have you ever been in jail? ◻ Yes ◻ No
Do you wear protective gear, including seat belts? ◻ Yes ◻ No
◻ Excessive television/video game/internet/cell phone use
School/Grade_____
◻ Attends school regularly
How are you doing in school?_____
◻ Special classes_____
◻ Trouble at school _____
◻ Participates in extracurricular activities_____

Relationship/Sex education: ✓ ***Check those that apply***
Has anyone ever touched you in a sexual way or made you touch them when you did not want to? ◻ Yes ◻ No
Are you in a relationship? _____ Male _____ Female
Do you feel safe in your relationship? ◻ Yes ◻ No
Pressure to have sex ◻ Yes ◻ No
Sexually Active? ◻ Yes ◻ No
Method of contraception_____ ◻ NA
Do you have any children? ◻ Yes ◻ No _____
*STI/HIV screening _____ ◻ NA
If positive see Periodicity Schedule

Physical Health

Current Health Indicators: ✓ ***Check those that apply***
◻ No change ◻ LMP_____ ◻ NA

Changes since last visit:

Nutrition:
◻ Normal eating habits _____
◻ Vitamins:_____
◻ Normal elimination ◻ Normal sleep patterns

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: ◻ Low risk ◻ High risk
Dyslipidemia Risk: ◻ Low risk ◻ High risk
Tuberculosis Risk: ◻ Low risk ◻ High risk

Physical Examination: ✓***= Normal limits***

◻ General Appearance	◻ Skin	◻ Neurological
◻ Reflexes	◻ Head	◻ Neck
◻ Eyes	◻ Ears	◻ Nose
◻ Oral Cavity/Throat	◻ Lungs	◻ Heart
◻ Pulses	◻ Abdomen	◻ Genitalia
◻ Back	◻ Extremities	

Possible Signs of Abuse ◻ Yes ◻ No

Health Education/Anticipatory Guidance:
◻ Discussed ◻ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, school achievement, family relationships, community interaction

Assessment: ◻ **Well Child** ◻ **Other Diagnosis**

Labs:

Referrals*: *(see above)* ◻ Other
*** See Provider Manual for automatic referrals***

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: ◻ 12 years of age ◻ 13 years of age
◻ 14 years of age ◻ Other

[1]Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy, 43, 585-594.* Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry, 34,* 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSDT Checklist (PLC): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

An individual is considered to have screened positive if the sum of the numbered responses is 4 or greater. For assistance phone 844-HELP4WV (844-435-7498).

West Virginia Department of Health and Human Resources
BUREAU FOR PUBLIC HEALTH
West Virginia HealthCheck Program

West Virginia Department of Health and Human Resources
EPSDT/HealthCheck Program
Preventive Health Screen

Name: DOB:

Additional Documentation

Date: _____ ☐ Interperiodic Screen

Check box if this is an encounter outside of the defined periodicity for this child

100% Enteral Foods ☐ Yes ☐ No

If enteral foods, attach registered dietitian evaluation, most recent history and physical exam (H&P), height and weight, swallowing evaluation and labs.

Official Use Only:

Medical Necessity Form

It is the responsibility of the ordering healthcare provider to complete this medical necessity form and provide adequate documentation or information of the plan of treatment. The healthcare provider then gives this information either to the patient or directly to the treatment provider. The treatment provider must be enrolled in West Virginia Medicaid.

A. Patient's Medical ID Number: _____

B.

ICD-10 Code(s)	Clinical Diagnosis

C.

Item or Service Prescription	Length of need (# of months)	Amt/Mo Requested

D. Clinical Indication(s) for Item(s)/Service(s) Requested:

_____

_____

E. Provider Certification

I certify that I have examined the member as part of an EPSDT periodic or interperiodic screen and the services requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not convenience items for the member or any individual involved with the member's care. I certify that the member or his/her representative has been offered a choice of vendors.

_____ _____

Print Provider/Clinic Name *Provider Signature*

_____ _____

Medicaid ID Number *Date*