EHS

Orange County Head Start, Inc.

WELL CHECK FORM

PATIENT INFORMATION

Child's Name _____ Date of Birth _____ Phone Number _____

Parent/Guardian Name _____ Address _____

HEAD START follows the AAP Bright Futures EPSDT recommendations. Please do not leave any of the below sections blank.

PLEASE INDICATE WHICH WELL CHECK THIS IS (Provider Use Only):

☐ **3-5 DAYS** ☐ **1 MONTH** ☐ **2 MONTH** ☐ **4 MONTH** ☐ **6 MONTH**
☐ **9 MONTH** ☐ **12 MONTH** ☐ **15 MONTH** ☐ **18 MONTH** ☐ **24 MONTH** ☐ **30 MONTH**

TB SCREENING
(REQUIRED at 1,6,12, & 24 MONTHS)

☐ **NOT at risk**

☐ **AT RISK** (Skin Test Required)

→ **Results must be within last 12 months**
Date Given: _____
Date Read: _____
Results: _____ mm ☐ Negative ☐ Positive

NEWBORN SCREENINGS (REQUIRED BETWEEN 0-2 MONTHS)

Hearing Screening

	RIGHT EAR	LEFT EAR
Passed	☐	☐
Failed	☐	☐

Blood Screening
☐ Normal
☐ Abnormal
→ Follow Up Date: _____

Bilirubin Test
☐ Normal
☐ Abnormal
→ Follow Up Date: _____

Heart Screening
Critical congenital heart defect detected?
No ☐ Yes ☐
Follow Up Date: _____

PHYSICAL EXAMINATION

Screening Requirement	Normal	Abnormal
General Appearance		
Arms/Legs		
Eyes		
Ears/Nose/Throat		
Skin		
Muscles/Bones/Joints		
Heart		
Lungs		
Urinary/Genitalia		
Stomach/GI		
Glands/Lymphatic/Thyroid		
Neurological/Cognitive		
Motor Ability		
Speech/Communication		
Oral Health Risk Assessment (6, 9, 12, 18, 24, & 30 Month WC)	**No Concern**	**Concern**
Fluoride varnish Applied? (6-30 Month WC)	**Yes**	**No**
Maternal Depression Screening (1, 2, 4, & 6 Month WC)	**No Concern**	**Concern**
Anticipatory guidance given?	**Yes**	**No**

REQUIRED TESTS/EVALUATIONS

Growth Assessment: Length: _____ Weight: _____
Head Circumference (0-24 Month WC): _____
Dyslipidemia Screening (24 Month WC): ☐ Not at risk ☐ At Risk

Hemoglobin/Hematocrit (RISK ASSESSMENT AT 4, 15-30 MONTHS)
☐ **NOT at risk** ☐ **AT RISK** → **RESULTS:** _____
(12 Month WC)
Hemoglobin: _____ or Hematocrit: _____
Iron Rx: ☐ Yes ☐ No Re-Check Due by: _____

Lead Screening (6, 9, 12, 18, & 24 Month WC)
☐ **NOT at risk** ☐ **AT RISK** (Test Required) → **Lead Value (12m & 24m)** _____
Re-Check (If Applicable) Due by: _____

Developmental Screening (9, 18, & 30 Month WC)
Appropriate developmental milestones for age?
☐ **Yes** ☐ **NO** **If no, indicate concerns/referrals below:**

Autism Screening (18 & 24 Month WC): ☐ No Concern ☐ Concern ☐ Referred
Referred to: _____

Explain any abnormal findings and restrictions/recommendations for school:

HEAD START STAFF ONLY

Date Received (Stamp):

PROVIDER USE ONLY

Office Stamp:

EXAM DATE:
Physician:
Phone/Fax:
Signature: