

EHS

WELL CHECK FORM

PATIENT INFORMATION

Child's Name _____

Date of Birth _____

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 <input type="checkbox"/> <input type="checkbox"/> Failed <input type="checkbox"/> <input type="checkbox"/>		Blood Screening <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Follow Up Date: _____
Bilirubin Test <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Follow Up Date: _____		Heart Screening Critical congenital heart defect detected? No <input type="checkbox"/> Yes <input type="checkbox"/> 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		

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 Not at risk
 At risk → **Lead Value** _____ **Follow up Appt.:** _____

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:

NEXT EXAM DATE:

IF A CONCERN IS PRESENT, PLEASE EXPLAIN:

	No Concern	Concern
Psychosocial/Behavioral Assessment	No Concern	Concern
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

HEAD START STAFF ONLY

Date Received (Stamp):

PROVIDER USE ONLY

Office Stamp:

EXAM DATE:

Physician:

Phone/Fax:

Signature: