

Screen Date _____

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

18, 19 and 20 Year Form

Name _____ DOB _____ Age _____ Sex: M F

Weight _____ Height _____ BMI _____ Pulse _____ BP _____ Resp _____ Temp _____ Pulse Ox (optional) _____

Allergies NKDA _____

Current meds None _____

Child with special health care needs _____ IEP/section 504 in place _____

Accompanied by N/A Parent Grandparent Other _____

Medical History

Initial Screen Periodic screen

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

Family health history reviewed _____

Concerns and/or questions _____

Social/Psychosocial History

What is your living situation _____

Are you in school? No High school College/vocational

Working? Yes No _____

What are your future plans? _____

What interests do you have outside of school and/or work? _____

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? Yes No _____

How much **stress** are you and your family under **now**?

None Slight Moderate Severe

What kind of stress? (✓ Check those that apply)

Relationships (partner, family and/or friends) School/work

Drugs Alcohol Violence/abuse (physical, emotional and/or sexual) Family member incarcerated Lack of support/help

Financial/money Emotional loss Health Insurance

Other _____

Concerns and/or questions _____

Traumatic Stress Reactions/PCL-C¹

***Positive screen = numbered responses 4 or greater**

Feelings over the past 2 weeks: (✓ Check one for each question)

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/Patient Health Questionnaire (PHQ-2)

***Positive screen = numbered responses 3 or greater**

***If Positive see Periodicity Schedule for link to PHQ-9**

Feelings over the past 2 weeks: (✓ Check one for each question)

Little interest or pleasure in doing things: Not at all

Several days(1) More than ½ the days(2)

Nearly every day(3)

Feeling down, depressed, or hopeless: Not at all

Several days(1) More than ½ the days(2)

Nearly every day(3)

Risk Indicators (✓ Check those that apply)

None identified *Tobacco use Cigarettes # per day _____

E-Cigarettes *Chew Passive Smoke Risk

*Alcohol use _____

*Drug use (prescription or otherwise) _____

***If positive see Periodicity Schedule for links to CRAFT**

and/or SBIRT screening tools

Access to firearm(s)/weapon(s) Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? Yes No NA

Witnessed violence/abuse Threatened with violence/abuse

Thoughts/plans to harm Self Others Animals NA

Do you wear protective gear, including seat belts? Yes No

Excessive television/video game/internet/cell phone use

Are you in a relationship? Yes (Male Female) No

Are you sexually active? Yes No

Method of contraception _____

Do you have children? Yes No _____

General Health

Growth plotted on growth chart

BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? Yes No

Fruits/Vegetables/Lean protein per day _____

Vitamins _____

Normal elimination _____

Physical activity/exercise an hour most days

Type of physical activity/exercise _____

Normal sleeping patterns? Yes No

Hours of sleep each night? _____

Oral Health

Date of last dental visit _____

Current oral health problems _____

Vision Acuity Screen: (Subjective 18-20 years)

R _____ L _____

Wears glasses? Yes No

Hearing Screen (Objective once between 18 and 20 years)

20db@

R ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

L ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

R ear: _____ 6000HZ _____ 8000HZ

L ear: _____ 6000HZ _____ 8000HZ

Wears hearing aids? Yes No

¹Lang, 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 PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.

Name _____ DOB _____ Age _____ Sex: M F

***See Periodicity Schedule for Risk Factors**

***Anemia Risk (Hemoglobin/Hematocrit)**

Low risk High risk

***Tuberculosis Risk**

Low risk High risk

***Dyslipidemia Risk**

Low risk High risk

Fasting lipoprotein required once between 17 and 20 years

***STI Risk**

Low risk High risk

***HIV Risk**

Low risk High risk

HIV test required once between 15 & 18 years

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance N Abn _____

Skin N Abn _____

Neurological N Abn _____

Reflexes N Abn _____

Head N Abn _____

Neck N Abn _____

Eyes N Abn _____

Ears N Abn _____

Nose N Abn _____

Oral Cavity/Throat N Abn _____

Lung N Abn _____

Heart N Abn _____

Pulses N Abn _____

Abdomen N Abn _____

If female:

LMP _____ Regular Irregular

Bleeding Normal Heavy

Cramping No Slight Severe

Genitalia N Abn _____

Back N Abn _____

Hips N Abn _____

Extremities N Abn _____

Possible Signs of Abuse Yes No

Concerns and/or questions _____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information

https://brightfutures.aap.org)

Social Determinants of Health

- Interpersonal violence
- Living situation and food security
- Family substance use (tobacco, alcohol, drugs)
- Connectedness with family and peers
- Connectedness with community
- School/work performance
- Coping with stress and decision making

Physical Health and Health Promotion

- Oral health
- Body image
- Healthy eating
- Physical activity and sleep
- Transition to adult care

Emotional Well-being

- Mood regulation and mental health
- Sexuality

Risk Reduction

- Pregnancy and sexually transmitted infections
- Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
- Acoustic trauma

Safety

- Seat belt and helmet use
- Driving and substance use
- Sun protection
- Firearm safety

Other _____

Plan of Care

Assessment Well Child Other Diagnosis

Immunizations

UTD Given, see immunization record Entered into WVSIIS

Labs

- Hemoglobin/hematocrit *(if high risk)*
- TB skin test *(if high risk)*
- Fasting lipoprotein (once between 17 and 20 years and/or high risk)**
- STI test *(if sexually active and/or high risk)*
- HIV test (once between 15 & 18 years, if sexually active and/or high risk)**
- Other _____

Referrals

- Mental/behavioral health/trauma- **Help4WV.com/1-844-435-7498**
- Substance abuse- **Help4WV.com/1-844-435-7498**
- Dental Vision Hearing
- Other _____

Family Planning (FP) **1-800-642-9704**

Children with Special HealthCare Needs (CSHCN)

1-800-642-9704

Transition to adult-oriented health care/medical home

Prior Authorizations

For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit 19 years of age 20 years of age

Other _____

Screen has been reviewed and is complete

Please Print Name of Facility or Clinician

Signature of Clinician/Title