KAN Be Healthy (EPSDT) Screening Form

I.D. Number:______________________

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen

PHYSICAL GROWTH

T ________ **Weight** __________ **(lbs/kg)** ________ **th%** **Weight/Length** ________ **%**

P ________ **Length** (Birth to 24 months) ________ cm/in **Standing Height** (2 - 20 years) ________ cm/in

R ________ **BMI** __________ ________ **th%**

BP ________ BMI ≥ 85%: recommend appropriate nutrition input and physical activity.

Update Growth Chart (required at each screen)

Male ☐
Female ☐

Head Circ (≤ 24 months) ________ **cm/in** ________ **th%**

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.
☐ No changes in medical Hx unless indicated.
☐ Previous Hx reviewed from______________ visit.
☐ Patient currently in Foster care, no previous hx available.

Present Concern: ______________________

Medications: ______________________

Serious Illness/Accidents: (including Hospital or ER visits) ☐ No ☐ Yes (date & type)

Allergies (food & drug) ______________________

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐ Yes (date & type)

(Circle and indicate the relationship with disease / problem. **P**-Parent, **G**-Grandparent, **B**-Brother, **S**-Sister, **Self**)

Allergies (food & drug)	________	Drug or ETOH Abuse	________	Mental Illness	________
Asthma	________	Earaches	________	Obesity	________
Birth defects	________	Epilepsy/Seizures	________	Scoliosis/Arthritis	________
Blood Disorder/ Sickle Cell	________	Headache	________	Speech, Visual, Hearing	________
Cancer	________	High Blood Pressure	________	Ulcers/Colitis	________
Colds/sore throat	________	Kidney/Liver Disease	________	Urinary/Bowel	________
Diabetes	________	Lung Disease	________	Heart Disease/Stroke	________

BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	Lung sounds?
Cardiovascular	☐	☐	Murmur?
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Ages 0 to 3 yr - Corneal Light Reflex Present: Yes ☐ No ☐
Ages 3 yr thru 20 - Bruckner Exam: Pass ☐ Refer ☐
All ages - Outer Inspection: Normal ☐ Abnormal ☐
Eye Tracking: Pass ☐ Refer ☐ PERRLA: Pass ☐ Refer ☐
Ocular Motility(strabismus/cross cover test):Pass ☐ Refer ☐

Ages 3 thru 20:
Distance Acuity - Tool used:________ Score: L____ R____ Both______
Near Acuity - Tool used: ________ Score: L____ R____ Both______
Last exam:________ Further comments (see below)

NUTRITION

☐ WIC participant
☐ Referred to WIC
☐ Breast Feeding ☐ Formula
Amount & how often: ____________

Number of Servings per day

Bread/Cereal ______ Dairy ______
Fat/Sweet/Sugar ______ Fruit ______
Meat/Bean/Egg ______ Vegetable ______
Fluid Intake: water ______ oz. Soda ______
Milk ______ oz. Juice ______

PHYSICAL ACTIVITY

☐ Biking ☐ Basketball ☐ play outside
☐ Skating ☐ Walking ☐ other sports

How many hours screen time/Day? (i.e. TV, Games, PC)
☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No
If "yes", then complete following :
1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ No

Referred to:

LABORATORY

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes ☐ No ☐ Indicate further follow-up in Plan of Care.

IMMUNIZATIONS

Copy of record in chart
Current ☐
Behind ☐
Unknown ☐
Requested from Parent ☐
Referred to VFC provider ☐

Needs (circle): Rota
HepB DTaP Flu
Hib IPV MMR
MCV4 MPSV4 PCV
Varicella HepA HPV
Other:

DEVELOPMENTAL / EMOTIONAL

Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.

Children < 6 yrs. A completed developmental screening tool **to include the screener's interpretation and report** regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care.

Children 6-21 yrs. A completed developmental screening tool **to include the screener's interpretation and report** or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care.

Developmental Tool used:____________

Sleep Habits ______ Tired / overactive? ______
Discipline: ______ Vocational concerns? ______
Peer Interaction: ______ Exercise ______
Grade Level ______ Average Marks ______
Special Education: ______ Special Needs: ______
Any emotional or behavioral problems? ______
Emotional Observations:____________

DENTAL

Sees Dentist? Yes ☐ No ☐
Last dental exam date: ___/___/_____
times brushes/day: ______
Dental Referral (annually at a minimum 1-20yr)
Yes ☐ No ☐ ~ Fluoride Varnish? Yes ☐ No ☐

HEARING SCREEN

Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report.

Age birth to 4, perform Risk Indicators for Hearing Loss and Hearing Developmental Scales Pass ☐ Refer ☐
Hearing Health History >4: Pass ☐ Refer ☐
Or Screen Procedure:

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline
2. Oral /Dental
3. Development
4. Physical Activity
5. Family Planning
6. Immunizations
7. Lifestyle
8. Nutrition
9. Parenting
10. Safety/Poisons
11. Substance Abuse
12. Self Testicular Exam
13. Self Breast Exam
14. Sexuality
15. Exercise
16. Weapon Safety
17. Other:____________

RESULTS/PLAN OF CARE

Screening Results: ____________

Plan/Referrals (dental, vision, hearing, dietary, etc):____________

Screening Providers Signature: ____________

Recommended Return Date:

Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes ☐ No ☐
Parent/Caregiver and/or Patient Signature:____________
Date: ____________

(Licensed Physician, ARNP, PA, or Registered Nurse credentialed to perform KAN Be Healthy screens) form revised 12/6/07