

KAN Be Healthy (EPSDT) Non-Mandatory Screening Form

ID #: _____

Beneficiary Name				Date of Birth		Age		Date of Screen	
GROWTH	T	P	R	BP	WT	HT	%WT/HT		Head Circumference
				3-20 years old complete each time	_____ kg/lbs _____ th%	_____ cm/in _____ th%	<10 Years _____ th% BMI > 10 years _____ th%		Age 0-24 months _____ cm/in _____ th%
BENEFICIARY & FAMILY HISTORY	Allergies: _____								
	Present Concerns: _____								
	Family Medical History (Circle and indicate the relationship with disease / problem. P -Parent, G -Grandparent, B -Brother, S -Sister)								
	Allergies _____			High B/P _____			Epilepsy/Seizures _____		
Birth defects _____			Kidney/Liver Disease _____			Scoliosis/Arthritis _____			
Blood Disorder/Sickle Cell _____			Lung Disease _____			Speech, Visual, Hearing Problems _____			
Cancer _____			Mental Illness _____			Ulcers/Colitis _____			
Diabetes _____			Obesity _____			Urinary/bowel _____			
Drug or ETOH Abuse _____			Physical Handicaps _____			Other _____			
Heart Disease/Stroke _____			Retardation _____						
Beneficiary Medical History									
Birth History: _____			Serious Illness/ _____			<input type="checkbox"/> Refer to completed history form in chart.			
			Accidents: _____			<input type="checkbox"/> No changes in medical Hx unless indicated.			
Birth Weight: _____			Operations: _____			<input type="checkbox"/> Previous Hx reviewed from _____ visit.			
Birth Height: _____			Medications: _____						
Miscellaneous: _____									
ASSESSMENTS	Developmental Screening Tool Utilized (Screen under age 6.)								
	Tool Used (in file): _____								
	Results <input type="checkbox"/> Pass <input type="checkbox"/> Not Screened (Comments Required)								
	<input type="checkbox"/> Referred to _____								
DEVELOPMENTAL OBSERVATIONS	Developmental Emotional Observations (Screen age 6-20 years.)								
	Exercise: _____								
	Sleep Habits: _____								
	Discipline: _____								
EDUCATIONAL	School: Grade _____ Avg Marks _____								
	Days Missed _____ Special Ed. (✓) _____								
	Emotional: _____ Peer Interaction _____								
	Special Needs: _____								
IMMUNIZATIONS	<input type="checkbox"/> Copy of Record in Chart								
	<input type="checkbox"/> Current <input type="checkbox"/> In Process <input type="checkbox"/> Behind <input type="checkbox"/> Unknown								
	<input type="checkbox"/> Requested parent obtain record								
	Comments _____ (Provide dates if not located elsewhere in chart.)								
DIET	DTaP [] [] [] [] []								
	HIB [] [] [] [] []								
	IPV [] [] [] [] []								
	MMR [] [] [] [] []								
NUTRITION	HEP B [] [] [] [] []								
	Varicella [] [] [] [] []								
	Td Booster [] [] [] [] []								
	Other _____								
DIET	Referral: <input type="checkbox"/> No <input type="checkbox"/> Yes Referred to _____								
	Receiving Vitamin Supplement: <input type="checkbox"/> Yes <input type="checkbox"/> No WIC <input type="checkbox"/> No <input type="checkbox"/> Yes								
	Breast Feeding x per 24 hrs _____ Formula type, oz and x per 24 hrs _____								
	# _____ stools x 24 hrs # _____ wet diapers x 24 hrs Number of servings per day _____								
DIET	Dairy (milk & milk products) _____ Vegetable _____ Fruit _____								
	Bread/Cereals _____ Meat/Bean/Eggs _____ Fats, sweets, sugars _____								
	Fluid Intake (water, soda, juice, etc) _____								
	Comments _____								

Body Systems			
System	WNI	ABN	Comments (Describe any Abnormal Findings)
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	
Head-Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes-Ears-Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Oral/Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen/Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Trunk & Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed / Handouts Given

- | | | | | |
|------------------------|--------------------|-------------------|--------------------------|---------------------|
| 1. Behavior/Discipline | 4. Family Planning | 7. Nutrition | 10. Self Breast Exam | 13. Substance Abuse |
| 2. Dental | 5. Immunizations | 8. Parenting | 11. Self Testicular Exam | 14. Weapon Safety |
| 3. Development | 6. Lifestyle | 9. Safety/Poisons | 12. Sexuality | 15. Other _____ |

BLOOD LEAD

Blood Lead Level Verbal Screen (Due at every KAN Be Healthy Screen from 6 to 72 months.)

1. Live in or visit a house or apartment built before 1960? (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have a family member with an elevated blood lead level?	<input type="checkbox"/>	<input type="checkbox"/>
4. Interact with an adult whose job or hobby involves exposure to lead? (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and making pottery)	<input type="checkbox"/>	<input type="checkbox"/>
5. Live near a lead smelter, battery plant or other lead industry? (Ammunition/explosives, auto repair/auto body, cable/wire stripping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten metal (foundry work).	<input type="checkbox"/>	<input type="checkbox"/>
6. Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?	<input type="checkbox"/>	<input type="checkbox"/>

A. Blood Lead Level test is due @ 12 & 24 months of age. **Blood Lead Level Results Pending**

B. Any one or more "Yes" response requires a Blood Lead Test.

C. If not previously tested (at 12 or 24 months), blood lead level test is due between 36 & 72 months of age. Results _____ ugdL

LABORATORY

Hemoglobin / Hematocrit
(Due @ age 9 months & 15 years.)
Hgb _____ Hct _____
 H&H Pending
Date WIC results obtained _____

Urinalysis
(Due @ age 5yrs & 15 years.)

Dip stick
 Unable to obtain
 Full UA pending
(Maintain results in file.)

VISION SCREEN

Last Eye Exam date _____

Referred to _____

Eye Tracking (0 - 3 yr. - each screen) Pass Referred

Distance Acuity (Snellen Eye Chart Results -- age 3 - 20 yrs)

Left	Right	Both	<input type="checkbox"/> Pass	<input type="checkbox"/> Referred
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DENTAL

Sees Dentist Yes No

Date of last dental exam? _____

of times brushed teeth/day _____

Dental Referral (20 years and under)

Yes No

HEARING SCREEN

Paper Screen (Optional forms include: General Hearing Health History, Risk Indicators for Hearing Loss Checklist, and Hearing Developmental Scales.)

Audiometric Screen (Optional)

Left	<input type="checkbox"/> Pass	<input type="checkbox"/> Referred	<input type="checkbox"/> Last screen date _____
Right	<input type="checkbox"/> Pass	<input type="checkbox"/> Referred	<input type="checkbox"/> Referred to _____
			<input type="checkbox"/> Unable to screen (comments) _____

Tympanometry Screen (Optional)

Left	<input type="checkbox"/> Pass	<input type="checkbox"/> Referred
Right	<input type="checkbox"/> Pass	<input type="checkbox"/> Referred

OTHER

Assessment Results _____

Plan/Referrals _____

Return _____

Signature of Licensed Physician or Nurse approved to perform health assessments. _____ Date _____