Well Care (Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)) Exam Forms and Anticipatory Guidance

The Well Care (EPSDT) Exam Forms, are revised as of 2/06 as are the Anticipatory Guidance tables that accompany the forms. These forms and tables should be used from birth through age 20. The new forms consist of full pages for each age or age range to give providers more room to record comments regarding the findings from each screen and an expanded anticipatory guidance section. These forms contain the recommended elements of screens, recommended immunizations and anticipatory guidance suggested by the American Academy of Pediatrics, the Centers for Disease Control, the American Medical Association and other professional organizations. Additional information about the elements of the screens and the anticipatory guidance questions can be found at [http://brightfutures.aap.org/web/](http://brightfutures.aap.org/web/). This website offers information for medical professionals, public health professionals and parents and other interested community members about child development and age-appropriate well care.

The Anticipatory Guidance Tables attached have been revised and expanded. These tables, like the revised anticipatory guidance sections of the Well Care EPSDT Tracking Forms, will assist providers in providing comprehensive age-appropriate anticipatory guidance at each well child visit. They provide easier-to-read and slightly more detailed lists of the elements of anticipatory guidance appropriate for each exam and can serve as a useful reference.

The Revised Well Care EPSDT Exam Forms have been approved for use by DSS, and all the managed care organizations in HUSKY A, Connecticut’s Medicaid Managed Care, and HUSKY B, the Connecticut SCHIP Program. These forms include all the required parts of an EPSDT screen. The Department encourages all providers of EPSDT screens to use the new Well Care EPSDT Tracking Forms which can assist providers in delivering comprehensive well child screens.

**Coding**

These forms list the appropriate preventative screening procedure code(s), from the series 99381-99395 for each age range which should be used to obtain reimbursement for an EPSDT screen, in the upper right hand corner of the page. Other ways to report well child exams include:

- An Evaluation and Management Code from the series 99201-99215 with an appropriate well care diagnosis (V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9)
- In a clinic setting, revenue center codes 51X with an appropriate well child care diagnosis (V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9) to indicate provision of a comprehensive well care visit.
- T1015, the general clinic encounter code must be combined with either age-appropriate preventative care codes, or E and M codes combined with a well-child care diagnosis, to indicate a well care visit.

Note: Use of these other codes instead of a preventative care procedure code enable a visit to count as a well child visit when DSS or HUSKY MCOs determine how many well child visits each child has received per year. However, use of the new forms does not change DSS or MCO policy regarding reimbursement for specific codes.
### 2 – 14 Day Old Well Care Exam (EPSDT) Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99381-New, 99391-Estab.</td>
</tr>
</tbody>
</table>

**Accompanied by:**

- Allergies: □ NKA ____________
- Current Medication(s)

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>Head Circ:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

Parental Comments/Concerns:

Nutritional Screen: Breast Feeding: _______________ Formula (type): _______________

Developmental Screen: Age Appropriate? (e.g., rooting reflex, startle, suck & swallow) Yes ________ No ________

If suspicious, specific objective testing performed ________________________________

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/Hair/Nails</td>
<td>Normal</td>
<td>Describe abnormal finding:</td>
</tr>
<tr>
<td>Ear/Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td></td>
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<tr>
<td>Mouth/Throat/Teeth</td>
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<tr>
<td>Nose/Head/Neck</td>
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<td>Heart</td>
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<td>Lungs</td>
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<td>Abdomen</td>
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<td>Genitourinary</td>
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<tr>
<td>Extremities</td>
<td></td>
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<tr>
<td>Back/Hips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Newborn PKU (&gt;72 hrs) prenatal labs/history</td>
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<td></td>
</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

- Was Hepatitis B given at birth? Yes ________ No ________
- Pt. needs immunizations? Yes ________ No ________
- Shot Record initiated? Yes ________ No ________

**ANTICIPATORY GUIDANCE**

- Breast or formula, feeding frequency – amount
- Early dental decay
- Supine sleep position
- Injury prevention/"babyproofing"
- Safety with siblings and pets
- Drowning prevention
- Car seat/auto safety
- "Shaken baby syndrome"
- Signs of Illness
- Temperature taking, When to contact doctor
- Emergency/911
- Passive smoke
- Parenting practices
- "Safe at home"
- Potential for abuse
- Postpartum adjustment
- Family involvement
- Parent/infant attachment
- Next appointment

**REFERRALS:**  □ WIC □ Birth to Three □ Specialty □ Other

**Date Consult Report Received:**

Clinician Name (print): ______________________
Clinician Signature: ______________________
See Additional/Supervisory Note? Yes No

Update 1-06

**Bold** = First asked this age
# 1 Month Old Well Care Exam (EPSDT) Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – <strong>circle one</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>99381-New, 99391-Estab</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accompanied by:</th>
<th>Allergies: □ NKA</th>
<th>Current Medication(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**HISTORY:**

Parental Comments/Concerns:

**Nutritional Screen:** Breast Feeding: ___________________________ Formula (type): ___________________________

**Developmental Screen:** Age Appropriate? (e.g., responds to sounds, responds to parent’s voice, follows with eyes?)

Yes ______ No _____

If suspicious, specific objective testing performed ______

**Behavioral Screen:** Age appropriate? (parental interview)

Yes ______ No _____

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings:

- Skin/Hair/Nails
- Ear/Hearing
  (Hospital screening done?)
- Eyes/Vision (red reflex)
- Mouth/Throat/Teeth
- Nose/Head/Neck
- Heart
- Lungs
- Abdomen
- Genitourinary
- Extremities
- Back/Hips
- Neurological

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

<table>
<thead>
<tr>
<th>Was Hepatitis B given at birth?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shot Record initiated?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**ANTICIPATORY GUIDANCE**

- Breastfeeding/Formula exclusive
- Early dental decay
- Supine sleep position
- Injury prevention/Baby-proofing
- Safety with siblings and pets
- Drowning prevention/Sun safety
- Car seat/Auto safety
- “Shaken baby syndrome”
- Signs of Illness
- Temp. taking, when to call Dr.
- Emergency/911
- Passive smoke
- Parenting practices
- “Safe at home”
- Potential for abuse
- Child care safety
- Limit TV/Video exposure
- Postpartum adjustment
- Family involvement
- Parent/infant attachment
- Next appointment

**REFERRALS:**

<table>
<thead>
<tr>
<th>WIC</th>
<th>Birth to Three</th>
<th>Specialty</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Update 1-06

**Clinician Name (print):**

**Clinician Signature:**

**See Additional/Supervisory Note?**

Yes No

**Bold** = First asked this age
## Well Care Exam (EPSDT) Form

### Update 1-06

<table>
<thead>
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<th>Date</th>
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</tbody>
</table>

**Accompanied by:**

**Allergies:** ☐ NKA __________________

**Current Medication(s):**

<table>
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<tr>
<th>Weight:</th>
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<th>Head Circ:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

### HISTORY:

**Temp:**

**Pulse:**

**Resp:**

**Fluoride checked?** *(if well water)*

### Parental Comments/Concerns:

**Nutritional Screen:** Breast Feeding: __________________

**Formula (type):**

**Developmental Screen:** Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?)

Yes _____ No _____

If suspicious, specific objective testing performed

**Behavioral Screen:** Age appropriate? (parental interview)

Yes _____ No _____

### PHYSICAL EXAM

**Are the following normal?**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe abnormal findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/Hair/Nails</td>
<td></td>
</tr>
<tr>
<td>Ear/Hearing</td>
<td>(Hospital screening done?)</td>
</tr>
<tr>
<td>Eyes/Vision (red reflex)</td>
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<td>Mouth/Throat/Teeth</td>
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<td>Back/Hips</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
</tbody>
</table>

### ASSESSMENT & PLAN:

**IMMUNIZATIONS:**

<table>
<thead>
<tr>
<th>Pt. needs immunizations?</th>
<th>Yes _____ No _____</th>
<th>Delayed? _____ Deferred? _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given today?</td>
<td>Hep B _____ DTaP _____ IPV _____ Hib _____ PCV _____ Other</td>
<td></td>
</tr>
</tbody>
</table>

### ANTICIPATORY GUIDANCE

- Breastfeeding/Formula exclusive
- Early dental decay
- Supine sleep position
- Injury prevention/“Baby-proofing”
- Safety with siblings and pets
- Drowning prevention/
  **Sun safety**
- Car seat/Auto safety
- “Shaken baby syndrome”
- Signs of illness
- Emergency/911
- Passive smoke
- Parenting practices
- “Safe at home”
- Potential for abuse
- Childcare safety
- Limit TV/Video exposure
- Postpartum adjustment
- Family involvement
- Parent/Infant attachment
- Next appointment

### REFERRALS:

- WIC
- Birth-to-Three
- Specialty
- Other

- Date Consult Report Received:

**Clinician Name (print):**

**Clinician Signature:**

**See Additional/Supervisory Note?** Yes No

**Bold = First asked this age**
**Well Care Exam (EPSDT) Form**

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<th>Percentile:</th>
<th>Head Circ:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

**Parental Comments/Concerns:**

**Nutritional Screen:** Breast Feeding: ___________________________ Formula (type): ___________________________

**Developmental Screen:** Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well)  Yes ______ No ______

If suspicious, specific objective testing performed ___________________________

**Behavioral Screen:** Age appropriate? (parental interview) ___________________________ Yes ______ No ______

**PHYSICAL EXAM**

Are the following normal? | Normal | Describe abnormal findings:
<table>
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<td>Ear/Hearing (Hospital screening done?)</td>
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<tr>
<td>Neurological</td>
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</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:** Pt. needs immunizations?  Yes ______ No ______ Delayed? _____ Deferred? _____

Given today?  Hep B ____ DTaP ____ IPV ____  Hib ____ PCV ____ Other ____

**ANTICIPATORY GUIDANCE**

- May introduce baby food slowly
- Early dental decay
- Supine sleep position
- Injury prevention/“Baby-proofing”
- Safety with siblings and pets
- Drowning prevention/Sun safety
- Car seat/Auto safety
- “Shaken baby syndrome”
- Signs of illness
- Emergency/911
- Passive smoke
- Parenting practices
- “Safe at home”
- Potential for abuse
- Child care safety
- Limit TV/Video exposure
- Postpartum adjustment
- Family involvement
- Fears and phobias
- Next appointment

**REFERRALS:**  WIC ☐  Birth-to-Three ☐  Specialty ☐  Other ☐

Clinician Name (print):  Clinician Signature:  See Additional/Supervisory Note?  Yes  No

Update 1-06  Bold = First asked this age
**6 Month Old**

**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
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<td></td>
<td></td>
<td>99381-New, 99391-Estab</td>
</tr>
</tbody>
</table>

Accompanied by: □ NKA

Current Medication(s)

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>Head Circ:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

Parental Comments/Concerns:

Nutritional Screen:
- Breast Feeding: 
- Formula (type): 
- Solids:

Developmental Screen:
- Age Appropriate? (e.g., rolls over, transfers small objects, vocal imitation) Yes ____ No ____

If suspicious, specific objective testing performed

Behavioral Screen:
- Age appropriate? (parental interview) Yes ____ No ____

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Hearing</td>
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<tr>
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<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCREENINGS:**

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

- Pt. needs immunizations? Yes ____ No ____ Delayed? ____ Deferred? ____

- Given today? Hep B ____ DTap ____ IPV ____ Hib ____ PCV ____ Other ____
- Influenza

**ANTICIPATORY GUIDANCE**

- Finger foods
- Introduce cup use
- Teething/Early dental decay
- Dental gum care
- Supine sleep position
- Injury prevention/ “Baby - proofing”
- Safety with siblings and pets
- Drowning prevention/
- Sun safety
- Car seat/Auto safety
- “Shaken baby syndrome”
- Emergency/911
- Passive smoke
- Parenting advice
- “Safe at home”
- Potential for abuse
- Child care safety
- Limit TV/Video exposure
- Family involvement
- Interaction with parents
- Parental/Sibling adjustment
- Fears and phobias
- Next appointment

**REFERRALS:** □ WIC □ Birth-to-Three □ Specialty □ Other

Clinician Name (print): ___________ Clinician Signature: ___________ See Additional/Supervisory Note? Yes ____ No ____

Date Consult Report Received: ___________

**Update 1-06**

**Bold** = First asked this age
### Well Care Exam (EPSDT) Form

**9 Month Old**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
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<th>Age</th>
<th>Proc. code – <strong>circle one</strong></th>
</tr>
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<tbody>
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</table>

99381-New, 99391-Estab

<table>
<thead>
<tr>
<th>Accompanied by:</th>
<th>Allergies: □ NKA</th>
<th>Current Medication(s)</th>
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</thead>
<tbody>
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</tbody>
</table>

<table>
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<th>Weight:</th>
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<th>Percentile:</th>
<th>Head Circ:</th>
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</table>

### HISTORY:

**Parental Comments/Concerns:**

<table>
<thead>
<tr>
<th>Dental Screen:</th>
<th>Brushing teeth?</th>
<th>Yes</th>
<th>No</th>
<th>Education re: Limit sugar intake/give healthy snacks?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Nutritional Screen:**

Breast Feeding:  
Formula (type):  
Solids:

### PHYSICAL EXAM

**Are the following normal?**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>LABS ORDERED:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Skin/Hair/Nails  
Ear/Hearing  
Eyes/Vision  
Mouth/Throat/Teeth  
Nose/Head/Neck  
Lungs  
Heart  
Abdomen  
Genitourinary  
Extremities  
Back/Hips  
Neurological

### ASSESSMENT & PLAN:

**IMMUNIZATIONS:**

Pt. needs immunizations?  
Yes  
No  
Delayed?

<table>
<thead>
<tr>
<th>Given today?</th>
<th>Hep B</th>
<th>Hib</th>
<th>DTap</th>
<th>PCV</th>
<th>Influenza</th>
<th>IPV</th>
<th>Other</th>
</tr>
</thead>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Finger foods/Self-feeding
- Transition to cup
- Early dental decay
- Sleep practices
- Injury prevention/ “Babyproofing”/
- Poison Control #

Safety with Siblings and Pets  
Drowning Prevention/sun safety  
Car seat/auto safety  
"Shaken baby syndrome"  
Emergency/911  
Passive Smoke  
Parenting Advice  
“Safe at Home”  
Potential for abuse  
Child Care Safety  
Limit TV/Video Exposure  
Time with parents/reading  
Family Involvement  
Interactions with Parents  
Stranger Awareness  
Sibling interactions  
Parental Adjustment  
Family functioning  
Next appointment

**REFERRALS:**

<table>
<thead>
<tr>
<th>WIC</th>
<th>Birth to Three</th>
<th>Dental</th>
<th>Specialty</th>
<th>Other</th>
</tr>
</thead>
</table>

Date Consult Report Received:

Clinician Name (print)  
Clinician Signature  
See Additional/Supervisory Note?  
Yes | No

**Update 1-06**  
**Bold = First asked this age.**
# Well Care Exam (EPSDT) Form

**Date** | **Last Name:** | **First Name:** | **Date of Birth** | **Age** | **Proc. code – circle one**
--- | --- | --- | --- | --- | ---
 | | | | | 99382-New, 99392-Estab

**Accompanied by:**

**Allergies:** □ NKA ____________

**Current Medication(s):**

| Weight | Percentile | Height | Percentile | Head Circ | Percentile | BMI | Percentile |
--- | --- | --- | --- | --- | --- | --- | --- |

## HISTORY:

**Parental Comments/Concerns:**

**Dental Screen:**

**Nutritional Screen:**

- **Breast Feeding:**
- **Formula (type):**
- **Supplements:**
- **Solids:**

## PHYSICAL EXAM

| Are the following normal? | Normal | Describe abnormal findings: | LABS ORDERED: |
--- | --- | --- | --- |

- **Skin/Hair/Nails**
- **Ear/Hearing**
- **Eyes/Vision**
- **Mouth/Throat/Teeth**
- **Nose/Head/Neck**
- **Lungs**
- **Heart**
- **Abdomen**
- **Genitourinary**
- **Extremities**
- **Back/Hips**
- **Neurological**

## ASSESSMENT & PLAN:

### IMMUNIZATIONS

- **Pt. needs immunizations?**
- **Yes**
- **No**
- **Delayed?**
- **Deferred?**

**Given today?**

- **Hep** __
- **Hib** __
- **IPV** __
- **PCV** __
- **Influenza** __
- **DTap** __
- **MMR** __

### ANTICIPATORY GUIDANCE PROVIDED

- **Nutrition/Self-feeding**
- **Drowning Prevention /sun safety**
- **Parenting Advice**
- **Social interactions/ expectations**
- **Transition to cup**
- **Potential for abuse**
- **Sibling interactions**
- **Sleep practices**
- **Child Care Safety**
- **Family functioning**
- **“Babyproofing”/Poison Control #**
- **Limit TV/Video Exposure**
- **Parental Adjustment**
- **Safety with Siblings and Pets**
- **“Safe at Home?”**
- **Stranger Awareness**
- **Next appointment**

### REFERRALS:

- **WIC**
- **Behavioral**
- **Birth to Three**
- **Dental**
- **Nutritional**
- **Specialty**
- **Other**

**Date Consult Report Received:**

---

**Clinician Name (print):**

**Clinician Signature:**

**See Additional/Supervisory Note?**

**Yes**

**No**

---

**Bold = First asked this age.**
**15 Month Old**

**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99382-New,  99392-Estab</td>
</tr>
</tbody>
</table>

Accompanied by:  
Allergies: NKA  
Current Medication(s):  

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>Head Circ:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

Parental Comments/Concerns:

Dental Screen:  
Daily toothbrushing?  Yes  No  Education re: Frequency of sugar intake/ Healthy Snacks?  Yes  No

Nutritional Screen:  
Breast/whole milk:  
Table foods:  
Supplements:  
Cup:  

**PHYSICAL EXAM**

Are the following normal? Normal  Describe abnormal findings:  

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Hearing</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Lungs</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Heart</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Extremities</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Back/Hips</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Neurological</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
</tbody>
</table>

**LABS ORDERED:**

<table>
<thead>
<tr>
<th>Tuberculin Test (perform if at risk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Lead Risk Assessment</td>
</tr>
<tr>
<td>Blood lead test (if not previously done)</td>
</tr>
</tbody>
</table>

**Additional Labs Ordered:**

<table>
<thead>
<tr>
<th>Hgb/Hct (HRisk/WIC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urisnalysis</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

<table>
<thead>
<tr>
<th>Pt. needs</th>
<th>immunizations?</th>
<th>Given today?</th>
<th>Hep B</th>
<th>DTaP</th>
<th>Hib</th>
<th>IPV</th>
<th>MMR</th>
<th>Varicella</th>
<th>PCV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Delayed?</td>
<td>Deferred?</td>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Nutrition/Exercise
- Dental caries prevention
- Sleep practices
- Injury prevention/"Child-proofing”
- Drowning Prevention/sun safety

- Car seat/auto safety
- "Safe at Home?”
- Potential for abuse
- Child Care Safety
- Time with parents/reading
- Parenting advice
- Limit TV/Video Exposure

- Sibling interactions
- Family functioning
- Parental Adjustment
- Social interactions/ Expectations
- Next appointment

**REFERRALS:**

- WIC
- Behavioral
- Birth to Three
- Dental
- Nutritional
- Specialty
- Other

**Date Consult Report Received:**

**Clinician Name (print)**  **Clinician Signature**  **See Additional/supervisory Note? Yes No**

**Update 1-06**

**Bold** = First asked this age.
**Well Care Exam (EPSDT) Form**

**18 Month Old**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99382-New, 99392-Estab</td>
</tr>
</tbody>
</table>

Accompanied by: Allergies: □ NKA ________________ Current Medication(s)

Weight: Percentile: Height: Percentile: Head Circ: Percentile: BMI: Percentile:

**HISTORY:**

Parental Comments/Concerns:

**Dental Screen:** Daily tooth brushing? Frequency of sugar intake, & snacks low in sugar, discussed? Yes No

**Nutritional Screen:** Breast/whole milk: Table foods: Supplements: Cup:

**Hearing Screen:** Within normal limits (ABR, OAE): Yes No  **Speech:** Within normal limits? Yes No

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings: LABS ORDERED:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>Tuberculin Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Hearing</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Verbal Lead Risk Assessment</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Blood lead test (if not previously done)</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Additional Labs Ordered:</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Hgb/Hct (HRisk/WIC)</td>
</tr>
<tr>
<td>Lungs</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>Heart</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Other:</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>Behavioral/Developmental Screen</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>□ Home Environment</td>
</tr>
<tr>
<td>Extremities</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>□ General Screen (e.g. PEDS or other tool)</td>
</tr>
<tr>
<td>Back/Hips</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td>□ Activities (risk level)</td>
</tr>
<tr>
<td>Neurological</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
<td></td>
</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:** Pt. needs immunizations? Yes No Delayed? Deferred?  

<table>
<thead>
<tr>
<th>Given today?</th>
<th>DTaP</th>
<th>Varicella</th>
<th>Influenza</th>
<th>HIB</th>
<th>Other</th>
</tr>
</thead>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Nutrition/exercise/vit.
- Dental caries prevention
- Sleep practices
- Injury prevention/“Childproofing”
- Safety with Siblings and Pets
- Drowning Prevention /sun safety
- Car seat/auto safety
- Fire Safety
- Violence/Prev.Gun Safety
- Emergency/911
- Passive Smoke
- Parenting advice
- “Safe at Home?”
- Potential for abuse
- Child Care Safety
- Time with parents/reading
- Limit TV/Video Exposure

**REFERRALS:**  

- Speech  
- WIC  
- Behavioral  
- Birth to Three  
- Dental  
- Nutritional  
- Other

**Date Consult Report Received:**

Clinician Name (print) Clinician Signature See Additional/Supervisory Note? Yes No

_Bold_ = First asked this age.
### 24 Month Old Well Care Exam (EPSDT) Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code –circle one 99382-New, 99392-Estab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accompanied by:</td>
<td>Allergies: □ NKA</td>
<td>Current Medication(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight:</td>
<td>Percentile:</td>
<td>Height:</td>
<td>Percentile:</td>
<td>Head Circ:</td>
<td>Percentile:</td>
</tr>
</tbody>
</table>

#### HISTORY:

- Parental Comments/Concerns:  
  - Fluoride checked? (If well water)
- Dental Screen: Routine:  
  - Urgent:  
  - Parent advised:  
  - Brushing teeth?  Yes  No
- Nutritional Screen: Adequate  
  Inadequate  
  Supplements:  
- Hearing Screen: Within normal limits (ABR, OAE):  Yes  No  
  Speech: Within normal limits?  Yes  No

#### PHYSICAL EXAM

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>LABS ORDERED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/Hair/Nails</td>
<td></td>
<td></td>
<td>Tuberculin Test (perform if at risk)</td>
</tr>
<tr>
<td>Ear/Hearing</td>
<td></td>
<td></td>
<td>Verbal Lead Risk Assessment</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
<td>Blood lead test referral</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td></td>
<td></td>
<td>Additional Labs Ordered:</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td></td>
<td></td>
<td>Hgb/Hct (HRisk/WIC)</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td>Uramalysis</td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Other:</td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td>Behavioral /Developmental Screen</td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td>Home Environment</td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
<td>General Screen (e.g. PEDS or other tool)</td>
</tr>
<tr>
<td>Back/Hips</td>
<td></td>
<td></td>
<td>Activities (risk level)</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ASSESSMENT & PLAN:

- IMMUNIZATIONS: Pt. needs immunizations?  Yes  No  
  - Delayed?  
  - Deferred?  
  - Given today?  
  - Hep B  
  - Varicella  
  - Influenza  
  - HIB  
  - Other  

#### ANTICIPATORY GUIDANCE PROVIDED

- Nutrition/exercise/vitamins  
- Dental caries prevention/dental care  
- Discontinue Pacifier Use  
- Injury prevention/ "Childproofing"  
- Poisonous Plant Awareness  
- Safety with Siblings and Pets  
- Drowning Prevention /sun safety  
- Car seat/auto safety  
- Violence Prevention/gun safety  
- Fire Safety/Burns  
- Emergency/911  
- Passive Smoke  
- Parenting advice  "Safe at Home?"  
- Potential for abuse  
- Child Care Safety  
- Toilet training  
- Read to child  
- Limit TV/Video exposure  
- Family involvement  
- Fears and Phobias  
- Peer Companionship  
- Self control  
- Sexual self-awareness  
- Next appointment  

#### REFERRALS:

- WIC  
- Behavioral  
- Birth to Three  
- Dental  
- Nutritional  
- Speech  
- Specialty  
- Other  

#### Date Consult Report Received:

- Clinician Name (print)  
- Clinician Signature  
- See Additional/Supervisory Note?  Yes  No

**Bold** = First asked this age.
# 3 Year Old Well Care EPSDT Tracking Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. Code – circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99382-New, 99392-Estab</td>
</tr>
</tbody>
</table>

**Accompanied by:**

**Allergies:** ☐ NKA ______________

**Current Medication(s):**

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

## HISTORY:

**Vision Exam (if able)**

- OD
- OS
- OU

**Temp:**

- Corrected / uncorrected

**Pulse:**

**Resp:**

**BP:**

**Fluoride checked?**

(If well water)

**Family involvement**

**Limits/Consequences**

**Social Interactions/Expectations**

**Sexual Self-awareness**

**Peer Companionship**

**Next appointment**

**Nutritional Screen:**

- Adequate
- Inadequate
- Supplements:

**Physical Activity:**

**Hearing Screen:**

Within normal limits? (Audiometry)

Yes   No

**Speech:**

Within Normal Limits?

Yes   No

## PHYSICAL EXAM

**Are the following normal?**

- Normal
- Describe abnormal findings:

**LABS ORDERED:**

- Tuberculin Test
- Verbal Lead Risk Assessment
- Blood lead test (If not done at age 24 months)
- Additional Labs Ordered:

**Nutritional Screen:**

- Adequate
- Inadequate
- Supplements:

**Behavioral /Developmental Screen**

- Home Environment
- General Screen (e.g. PEDS or other tool)
- Activities (risk level)
- School Readiness

**Genitourinary**

**Extremities**

**Back/Hips**

**Neurological**

**Home Environment**

**Activities (risk level)**

**School Readiness**

**IMMUNIZATIONS**

- Given Today?
- Hep A
- Hep B
- Varicella
- PCV

**ANTICIPATORY GUIDANCE PROVIDED**

- Nutrition/ exercise/ vitamins
- Car Seat /Auto safely
- “Safe at home?”
- Family involvement
- Limits/Consequences
- Social Interactions/Expectations
- Sexual Self-awareness
- Peer Companionship
- Next appointment

- Dental care
- Sport bike/helmet use
- Potential for abuse
- Social Interactions/Expectations

- Injury Prevention/Childproofing
- Violence Prev./Gun Safety
- Child Care Safety

- Poisonous Plant Awareness
- Pedestrian/Traffic Safety
- Reading/ Preschool

- Safety with Siblings and Pets
- Emergency/911
- Toilet training

- Drowning Prevention/Sun Safety
- Passive Smoke
- Limit TV/Video/ Exposure

- Discourage Thumbsucking

**REFERRALS:**

- WIC
- Behavioral/ Developmental
- Dental
- Nutritional
- Speech
- Other

**Date Consult Report Received:**

**Clinician Name (print)**

**Clinician Signature**

**See Additional/Supervisory Note?**

Yes   No

**Bold** = First asked this age.
**4 Year Old Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>99382-New, 99392-Estab</td>
</tr>
</tbody>
</table>

Accompanied by: 
Allergies: NKA: 
Current Medication(s): 

<table>
<thead>
<tr>
<th>Weight</th>
<th>Percentile</th>
<th>Height</th>
<th>Percentile</th>
<th>BMI</th>
<th>Percentile</th>
</tr>
</thead>
</table>

**HISTORY:**

<table>
<thead>
<tr>
<th>Vision Exam</th>
<th>Temp:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD</td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td></td>
</tr>
<tr>
<td>OU</td>
<td></td>
</tr>
</tbody>
</table>

Corrected / uncorrected 
Fluoride checked? 

**Parental Comments/Concerns:**

**Dental Screen:** Date of last exam: 
Next appt: 
Routine 
Urgent 
Parent advised 
(If well water) 

**Nutritional Screen:** 
Adequate 
Inadequate 
Supplements: 

**Physical Activity:** 

**Hearing Screen:** 
Within normal limits? (Audiometry) 
Yes 
No 
Speech: Within Normal Limits? 
Yes 
No 

**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>LABS ORDERED:</th>
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</thead>
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<tr>
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<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
<td>Verbal Lead Risk</td>
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<td>Mouth/Throat/Teeth</td>
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<td></td>
<td>Assessment</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td></td>
<td></td>
<td>Blood lead test (if not done since age 1)</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Hgb/Hct (HRisk/WIC)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:** (Confidential Documentation attached)

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Given Today:</th>
<th>Hep B</th>
<th>Td</th>
<th>MMR</th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Hep A</td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Good nutrition/Exercise
- Dental care
- Drowning/Sun Safety
- Car Seat/Auto safety
- “Safe at home?”
- Limit TV/Internet Use
- Dental care safety
- Violence prevention/Gun safety
- Fire Safety
- Reading to child/ preschool
- Self Control
- Passive Smoke
- Child Care Safety
- Toileting Habits
- Parenting advice
- Next appointment

**REFERRALS:**

- WIC
- Behavioral/ Developmental
- Dental
- Nutritional
- Speech
- Specialty
- Other

Date Consult Report Received: 

See Additional/Supervisory Note?

Clinician Name (print) 
Clinician Signature 
Yes 
No

Update 1-06

**Bold** = First asked this age range
**5 Year Old Well Care Exam (EPSDT) Form**

| Date | Last Name: | First Name: | Date of Birth | Age | Proc. code –first asked this age range
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99383-New, 99393-Established</td>
</tr>
</tbody>
</table>

Accompanied by: [ ] Current Medication(s)

Weight: Percentile: Height: Percentile: BMI: Percentile:

**HISTORY:**

<table>
<thead>
<tr>
<th>Vision Exam</th>
<th>Temp:</th>
<th>Pulse:</th>
<th>Resp:</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>OU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected / uncorrected</td>
<td>Fluoride checked?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parental Comments/Concerns:

Dental Screen: Date of last exam: ______ Next appt: ______ Routine _____ Urgent _____ Parent advised: (If well water)

Nutritional Screen: Adequate ________ Inadequate ________ Supplements: __________

Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ____ No ____

Hearing Screen: Within normal limits? (Audiometry) Yes ____ No ____ Speech: Within Normal Limits? Yes ____ No ____

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings:

<table>
<thead>
<tr>
<th>LABS ORDERED:</th>
<th>Tuberculin Test (perform if at risk)</th>
</tr>
</thead>
</table>

Skin/Hair/Nails

Ear/Hearing

Eyes/Vision

Mouth/Throat/Teeth

Nose/Head/Neck

Lungs

Heart

Abdomen

Genitourinary

Extremities

Back/Hips

Neurological

**ASSESSMENT & PLAN:** (Confidential Documentation attached)

IMMUNIZATIONS Given Today: PCV _____ Hep B _____ DTaP _____ IPV _____

MMR _____ Varicella _____ Hep A _____ Influenza _____ Other _____

ANTICIPATORY GUIDANCE PROVIDED

<table>
<thead>
<tr>
<th>Potential for abuse</th>
<th>Social Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good nutrition/Exercise</td>
<td>Dental care</td>
</tr>
<tr>
<td>Sports/injury prevention</td>
<td>Violence prevention/Gun safety</td>
</tr>
<tr>
<td>Child Care Safety</td>
<td>Toileting Habits</td>
</tr>
<tr>
<td>Dental care</td>
<td>Reading to child/School readiness</td>
</tr>
<tr>
<td>Drowning/Sun Safety</td>
<td>Parenting advice</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>Next appointment</td>
</tr>
<tr>
<td>Car Seat/Auto safely</td>
<td></td>
</tr>
<tr>
<td>Passive Smoke</td>
<td></td>
</tr>
<tr>
<td>Sport bike/Helmet use</td>
<td>&quot;Safe at home?&quot;</td>
</tr>
<tr>
<td>&quot;Safe at home?&quot;</td>
<td>Limit TV/Video/Internet Use</td>
</tr>
</tbody>
</table>

REFERRALS: [ ] WIC [ ] Behavioral [ ] Dental [ ] Nutritional [ ] Speech [ ] Specialty:

Date Consult Report Received:

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes ____ No ____

Update 1-06 Bold = First asked this age range
## 6 Year Old Well Care Exam (EPSDT) Form

### Update 1-06

**Bold** = First asked this age range

### Date Last Name: First Name: Date of Birth Age Proc. code **circle one**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code</th>
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</thead>
<tbody>
<tr>
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<td></td>
<td>99383-New, 99393-Established</td>
</tr>
</tbody>
</table>

Accompanied by: Allergies:NKA\[\] ____________ Current Medication(s)

<table>
<thead>
<tr>
<th>Weight</th>
<th>Percentile</th>
<th>Height</th>
<th>Percentile</th>
<th>BMI</th>
<th>Percentile</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### HISTORY:

#### Parental Comments/Concerns:

Vision Exam (if needed @) Temp: ________

<table>
<thead>
<tr>
<th>OD</th>
<th>Pulse:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OS</th>
<th>Resp:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| OU | BP
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Corrected / uncorrected

Fluoride checked?

#### Dental Screen:

Date of last exam: ________ Next appt: ________ Routine ________ Urgent ________ Parent advised ________

#### Nutritional Screen:

Adequate ________ Inadequate ________ Supplementation: ________

#### Developmental Screen:

Age Appropriate? (school attendance, school performance, social interactions) Yes ________ No ________

#### Hearing Screen:

Within normal limits? Audiometry (@ - if not done at school) Yes ________ No ________

### PHYSICAL EXAM

Are the following normal? Normal Describe abnormal findings:

#### LABS ORDERED:

- Tuberculin Test ________
- (perform if at risk)
- Verbal Lead Risk Assessment ________
- Blood lead test (perform once, at age up to 72 months) ________
- Additional Labs Ordered:
  - Hgb/Hct ________
  - Urinalysis ________
  - Other: ________

- Behavioral/Developmental Screen (or substitute GAPS or other tool):
  - Home Environment ________
  - Activities (risk level) ________
  - General Screen (e.g. PEDS or other) ________
  - School Attendance ________
  - School Performance ________
  - Social Interactions ________

### ASSESSMENT & PLAN: (Confidential Documentation attached □)

### IMMUNIZATIONS Given Today:

- MMR ________ Varicella ________ Hep A ________ Influenza ________ DTaP ________ Other ________ IPV ________

### ANTICIPATORY GUIDANCE PROVIDED

- Potential for abuse ________ Social Interaction ________
- Good nutrition/Exercise ________ Sports/Injury prevention ________ Child Care Safety ________ Age Appropriate Behavior ________
- Dental care ________ Violence prevention/Gun safety ________ Toileting Habits ________
- Drowning/Sun Safety ________ Fire Safety ________ Reading with child ________ Family Functioning ________
- Car Seat or Seat Belt/Auto safety ________ Passive Smoke ________ Limit TV/Video/Internet Use ________ Self Control ________
- Sport bike/Helmet use ________ “Safe at home?” ________ Parenting advice ________

### REFERRALS:

- Behavioral/Developmental ________ Dental ________ Nutritional ________ Specialty: ________ Other ________

Date Consult Report Received: ________

See Additional/Supervisory Note?

Clinician Name (print) Clinician Signature Yes ________ No ________
### 7-8 Year Old Well Care Exam (EPSDT) Form

#### Date

**Last Name:**

**First Name:**

**Date of Birth:**

**Age:**

**Proc. code**

- circle one
  - 99383-New,
  - 99393-Established

<table>
<thead>
<tr>
<th>Accompanied by</th>
<th>Allergies: NKA</th>
<th>Current Medication(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Percentile</th>
<th>Height</th>
<th>Percentile</th>
<th>BMI</th>
<th>Percentile</th>
</tr>
</thead>
</table>

#### HISTORY:

**Parental Comments/Concerns:**

**Dental Screen:** Date of last exam: ______ Next appt: ______ Routine ______ Urgent ______ Parent advised ______ (If well water)

**Nutritional Screen:** Adequate ______ Inadequate ______ Supplements: ______

**Hearing Screen:** Within normal limits? (@ - if not done at school) Yes ______ No ______ Physical Activity:

#### PHYSICAL EXAM

Are the following normal? Normal Describe abnormal findings:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Hearing</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Lungs</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Heart</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Extremities</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Back/Hips</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Neurological</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
</tbody>
</table>

#### ASSESSMENT & PLAN:

(Confidential Documentation attached □)

#### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Given Today</th>
<th>Hep B</th>
<th>PCV</th>
<th>Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep A</td>
<td>______</td>
<td>-----</td>
<td>----------</td>
</tr>
<tr>
<td>Influenza</td>
<td>______</td>
<td>-----</td>
<td>----------</td>
</tr>
</tbody>
</table>

#### ANTICIPATORY GUIDANCE PROVIDED

- Good nutrition/Exercise
- Dental/Flossing/Self care
- Drowning/Sun Safety
- Seat Belt/Auto safety
- Sport bike/Helmet use
- Afterschool/Child Care Issues
- Sex Education
- Sports/Injury prevention
- Violence prevention/Gun safety
- "Safe at home?"
- Afterschool/Child Care Issues
- Tobacco/Alcohol/Drugs/Inhalants
- Social Interaction
- Family Functioning

#### REFERRALS:

- Behavioral/Developmental
- Dental
- Nutritional
- Specialty: Other

#### Date Consult Report Received:

See Additional/Supervisory Note?

**Clinician Name (print):**

**Clinician Signature:** Yes ______ No ______

**Update 1-06**

**Bold = First asked this age range**
**Well Care Exam (EPSDT) Form**

### Date

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code—circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99383-New 99393-Established</td>
</tr>
</tbody>
</table>

### Accompanied by:

<table>
<thead>
<tr>
<th>Allergies:NKA □</th>
<th>Current Medication(s)</th>
</tr>
</thead>
</table>

### Weight: Percentile: Height: Percentile: BMI: Percentile:

### HISTORY:

#### Parental Comments/Concerns:

#### Dental Screen: Date of last exam: Next appt: Routine Urgent Parent advised

#### Nutritional Screen: Adequate _____ Inadequate _____ Supplements: __________

#### Developmental Screen: Age Appropriate? (school attendance, school performance, social interactions) Yes ___ No ___

#### Hearing Screen: Within normal limits? Yes ____ No ____ Adequate Sleep Yes ____ No ____

### PHYSICAL EXAM

#### Are the following normal? Normal Describe abnormal findings: LABS ORDERED:

- Skin/Hair/Nails
- Ear/Hearing
- Eyes/Vision
- Mouth/Throat/Teeth
- Nose/Head/Neck
- Lungs
- Heart
- Abdomen
- Genitourinary/Breast
- Extremities
- Back/Hips
- Neurological

#### LABS ORDERED:

- Tuberculin Test
- Hgb/Hct
- Lipid profile
- Other Tests:

#### ASSESSMENT & PLAN: (Confidential Documentation attached □)

### IMMUNIZATIONS

Given Today: Varicella ___________ Hep B _________ Td _________ MMR _________

### ANTICIPATORY GUIDANCE PROVIDED

- Good nutrition/Exercise
- Dental/Flossing/Self care
- Drowning/Sun Safety
- Seat Belt/Auto safely
- Sport bike/helmet use
- Sex Education
- Educational goals/Activities
- Violence prevention/Gun safety
- Limit TV/Video/Internet Use
- Tobacco/alcohol/drugs/inhalants
- Peer refusal skills/Gangs
- "Safe at home?"
- Afterschool/Child Care Issues
- Social Interaction
- Family Functioning
- Self Control
- Depression/Anxiety
- Conflict resolution skills
- Parenting advice
- Next appointment

### REFSERALS:

- Behavioral □  Dental □  Nutritional □  OB/GYN □  Specialty:

### Date Consult Report Received:

See Additional/Supervisory Note?

**Update 1-06**

**Bold = First asked this age range**
**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>99384-New, 99394-Estab age 12</td>
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<td></td>
<td></td>
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**Accompanied by:**

**Allergies:** NKA

**Current Medication(s):**

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<th>Height:</th>
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<th>BMI:</th>
<th>Percentile:</th>
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</table>

**HISTORY:**

**Vision Exam at Age 12**

<table>
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<tr>
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<th>OU</th>
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</table>

**Temp:**

**Pulse:**

**Resp:**

**BP**

**Fluoride checked?**

**Parental Comments/Concerns:**

**Accompanied by:**

**Current Medication(s):**

<table>
<thead>
<tr>
<th>Date Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Dental Screen:** Date of last exam: ____________

**Next appt:** ____________

**Routine** ____________

**Urgent** ____________

**Parent advised** ____________

**Nutritional Screen:** Adequate ____________

**Inadequate** ____________

**Supplements:** ____________

**Physical Activity:**

**Developmental Screen:** Age Appropriate? (school attendance, school performance, social interactions)

Yes ____________

No ____________

**Hearing Screen:** Within normal limits? Yes ____________

No ____________

Adequate Sleep Yes ____________

No ____________

**PHYSICAL EXAM**

**Are the following normal?**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe abnormal findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LABS ORDERED:**

**Tuberculin Test** ____________

**Hgb/Hct** ____________

**Urinalysis** ____________

**Lipid profile**

**Other Tests:** ____________

**Behavioral Screen** (or substitute GAPS or other tool):

- Home Environment
- Activities (risk level)
- Educational Goals
- Depression/Suicide
- Sexual Activity
- Drugs/Alcohol

**ASSESSMENT & PLAN:** (Confidential Documentation attached □)

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Given Today:</th>
<th>Hep B</th>
<th>Td</th>
<th>MMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hep A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Good nutrition/Exercise
- Dental/Flossing/Self care
- Drowning/Sun Safety
- Seat Belt/Auto safely
- Sport bike/Helmet use

- Sports/injury prevention
- Passive Smoke
- “Violence prevention/Gun safety
- Safe at home?”
- Sex Education/Counseling

- Educational goals/Activities
- Limit TV/Internet Use
- Tobacco/alcohol/drugs/inhalants
- Peer refusal skills/Gangs
- Social Interaction
- Family Involvement

- Self Control
- Depression/Axiety
- Conflict resolution skills
- Parenting advice
- Next appointment

**REFERRALS:**

- Behavioral
- Dental
- Nutritional
- OB/GYN
- Specialty
- Other

**Date Consult Report Received:**

**Clinician Name (print):**

**Clinician Signature:** Yes □

**Update 1-06**

**Bold = First asked this age range**
### 13, 14 Year Old

**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
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<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code – circle one</th>
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</thead>
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<tr>
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<td></td>
<td>99384-New, 99394-Estab</td>
</tr>
</tbody>
</table>

Accompanied by: 

Allergies: NKA: 

Current Medication(s)

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

- Vision Exam (if needed)
  - OD
  - OS
  - OU
  - Corrected / uncorrected

Temp: 

Pulse: 

Resp: 

BP: 

- Physical Activity:

**Parental Comments/Concerns:**

**Dental Screen:** Date of last exam: 

Next appt: 

Routine 

Urgent 

Parent advised 

**Nutritional Screen:** Adequate  

Inadequate  

Supplements: 

**Developmental Screen:** Age Appropriate? (school attendance, school performance, social interactions) 

Yes  

No  

**Hearing Screen:** Within normal limits? 

Yes  

No  

Adequate Sleep 

Yes  

No  

### PHYSICAL EXAM

Are the following normal? 

- Normal  

- Describe abnormal findings:

**LABS ORDERED:**

- Tuberculin Test (perform if at risk)

- Hgb/Hct

- Urinalysis

- Lipid profile (perform if at risk)

- Other Tests:

- Behavioral Screen (or substitute GAPs or other tool):
  - Home Environment
  - Educational Goals
  - Activities (risk level)
  - Drugs/Alcohol
  - Depression/Suicide
  - Sexual Activity

**ASSESSMENT & PLAN:** (Confidential Documentation attached)

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Given Today:</th>
<th>Hep B</th>
<th>Td</th>
<th>MMR</th>
</tr>
</thead>
</table>

- Varicella 

- Hep A 

- Influenza 

- Other 

**ANTICIPATORY GUIDANCE PROVIDED**

- Good nutrition/Exercise
- Dental/Flossing/self care
- Drowning/Sun Safety
- Seat Belt/Driving safety
- Sport bike/Helmet use

- Sports/injury prevention
- Violence prevention/Sun safety
- Parenting advice
- “Safe at home?”

- Sex Education/Counseling
- Educational goals/activities
- Limit TV/Internet Use
- Peer refusal skills/Gangs

- Family Functioning
- Self Control
- Conflict resolution skills
- Depression/anxiety

- Next appointment

**REFERRALS:**

- Behavioral
- Dental
- Nutritional
- OB/GYN
- Specialty:

**Date Consult Report Received:**

See Additional/Supervisory Note?

Clinician Name (print)  

Clinician Signature

**Update 1-06**

**Bold = First asked this age range**
**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code –circle one</th>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>99384-New, 99394-Estab</td>
</tr>
</tbody>
</table>

**Accompanied by:** [ ]

**Allergies:** NKA: __________

**Current Medication(s):**

<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

- **Vision Chart Exam:**
  - Age 15
  - OD: __________
  - OS: __________
  - OU: __________

- **Corrected / uncorrected:**

**Parental Comments/Concerns:**

**Dental Screen:**
- Date of last exam: ________
- Next appt: ________
- Routine: ________
- Urgent: ________
- Parent advised: ________

**Nutritional Screen:**
- Adequate: ________
- Inadequate: ________
- Supplements: ________

**Developmental Screen:**
- Age Appropriate? (school attendance, school performance, social interactions, future plans)
  - Yes: ________
  - No: ________

**Hearing Screen:**
- Within normal limits? ________
- Yes: ________
- No: ________
- Adequate Sleep: ________

**PHYSICAL EXAM:**

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>LABS ORDERED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin/Hair/Nails</td>
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<td></td>
<td>Tuberculin Test ________</td>
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<tr>
<td>Ear/Hearing</td>
<td></td>
<td></td>
<td>(perform if at risk)</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
<td>Hgb/Hct ________</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td></td>
<td></td>
<td>Urinalysis ________</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td></td>
<td></td>
<td>Lipid profile ________ (perform if at risk)</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td>Other Tests: ________</td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td>Behavioral Screen (or substitute GAPS or other tool):</td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td>- Home Environment</td>
</tr>
<tr>
<td>Genitourinary/Breast</td>
<td></td>
<td></td>
<td>- Education and Work Goals/ Future Plans</td>
</tr>
<tr>
<td>Pelvic Exam/STD Screening (if appropriate)</td>
<td></td>
<td></td>
<td>- Activities (risk level)</td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
<td>- Drugs/Alcohol</td>
</tr>
<tr>
<td>Back/Hips</td>
<td></td>
<td></td>
<td>- Depression/Suicide</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>- Sexual Activity</td>
</tr>
</tbody>
</table>

**ASSESSMENT & PLAN:** (Confidential Documentation attached)

**IMMUNIZATIONS Given Today:**

- Varicella ________
- Hep A ________
- Influenza ________
- Td ________
- MMR ________

**ANTICIPATORY GUIDANCE PROVIDED:**

- Good nutrition/Exercise
- Sports/injury prevention
- Dental/Flossing/Self care
- Violence prev/Gun safety
- Drowning/Sun Safety
- Parenting advice
- Seat Belt/Driving safety
- "Safe at home?"
- Sport bike/Helmet use
- Sex Education/Counseling
- Breast/Testicular self exam
- Educational goals/activities
- Limit TV/Internet Use
- Tobacco/Alcohol/Drugs/Inhalants
- Peer refusal skills/Gangs
- Social Interaction
- Family Functioning
- Self Control
- Depression/Angst
- Conflict resolution skills
- Transition Planning (age 16 on)
- Next appointment

**REFERRALS:**

- Behavioral
- Dental
- Nutritional
- OB/GYN
- Specialty: WIC

**Date Consult Report Received:**

**Clinician Name (print):**

**Clinician Signature:**

**Update 1-06**

**Bold = First asked this age range**
**Well Care Exam (EPSDT ) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Proc. code –<em>circle one</em></th>
<th>Current Medication(s)</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>99385-New,  99395-Estab</td>
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<table>
<thead>
<tr>
<th>Accompanied by:</th>
<th>Allergies:NKA:</th>
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</thead>
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<table>
<thead>
<tr>
<th>Weight:</th>
<th>Percentile:</th>
<th>Height:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
</tr>
</thead>
</table>

**HISTORY:**

**Vision Chart Exam-age 18**  
**Temp:**  
**Pulse:**  
**Resp:**  
**BP**

**Parental Comments/Concerns:**

**Dental Screen:** Date of last exam:  
Next appt:  
Routine  
Urgent  
Parent advised

**Nutritional Screen:**  
**Adequate**  
**Inadequate**  
**Supplements:**  
**Physical Activity:**

**Developmental Screen:**  
Age Appropriate? (School attendance, school performance, social interactions, future plans)  
Yes  
No

**Hearing Screen:**  
Within normal limits?  
Yes  
No  
**Adequate Sleep**  
Yes  
No

**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Normal</th>
<th>Describe abnormal findings:</th>
<th>LABS ORDERED:</th>
</tr>
</thead>
</table>

**Skin/Hair/Nails**  
**Ear/Hearing**  
**Eyes/Vision**  
**Mouth/Throat/Teeth**  
**Nose/Head/Neck**

**Lungs**

**Heart**

**Abdomen**

**Genitourinary/Breast**

**Pelvic Exam/STD Screening**

| Externities | Back/Hips | Neurological |

**Behavioral Screen** (or substitute GAPS or other tool):

- Home Environment
- Education and Work Goals/Future Plans
- Activities (risk)
- Drugs/Alcohol
- Depression/Suicide
- Sexual Activity

**ASSESSMENT & PLAN:** (Confidential Documentation attached)

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Varicella</th>
<th>Given Today:</th>
<th>Hep B</th>
<th>Td</th>
<th>MMR</th>
</tr>
</thead>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

- Good nutrition/Exercise
- Dental/Flossing/Self care
- Drowning/Sun Safety
- Seat Belt/Driving safety
- Sport bike/Helmet use
- Breast/Testicular self exam
- Educational goals/Activities
- Parenting advice
- “Safe at home?”
- Sex Education/Counseling
- Peer refusal skills
- Social Interaction
- Family Functioning
- Self Control
- Depression/anxiety
- Transition to Internist/Family Practice/GP

**REFERRALS:**  
Behavioral  
Dental  
Nutritional  
OB/GYN  
Specialty:  
WIC

**Date Consult Report Received:**  
See Additional/Supervisory Note?

Clinician Name (print)  
Clinician Signature

**Update 1-06**  
**Bold = First asked this age range**
# RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

<table>
<thead>
<tr>
<th>AGES</th>
<th>2-4 DAYS</th>
<th>1 MONTH</th>
<th>2 MONTHS</th>
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<tbody>
<tr>
<td><strong>NUTRITION and EXERCISE</strong></td>
<td>Breast or formula Feeding frequency - amount</td>
<td><strong>Breastfeeding/Formula exclusive</strong></td>
<td><strong>Breastfeeding/Formula exclusive</strong></td>
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<tr>
<td><strong>DENTAL HEALTH</strong></td>
<td>Early dental decay</td>
<td>Early dental decay</td>
<td>Early dental decay</td>
</tr>
<tr>
<td><strong>HEALTH AWARENESS/SAFETY HABITS</strong></td>
<td>Signs of Illness Temperature taking, when to contact doctor Emergency/911 Passive smoke Parenting practices “Safe at home” Potential for abuse</td>
<td>Signs of Illness Temperature taking, when to contact doctor Emergency/911 Passive smoke Parenting practices “Safe at home” Potential for abuse <strong>Child care safety Limit TV/Video exposure</strong></td>
<td>Signs of illness Emergency/911 Passive smoke Parenting practices “Safe at home” Potential for abuse Child care safety Limit TV/Video exposure</td>
</tr>
<tr>
<td><strong>PSYCHOSOCIAL ISSUES</strong></td>
<td>Postpartum adjustment Family involvement Parent/Infant attachment</td>
<td>Postpartum adjustment Family involvement Parent/Infant attachment</td>
<td>Postpartum adjustment Family involvement Parent/Infant attachment</td>
</tr>
<tr>
<td><strong>FOR ADDITIONAL INFORMATION</strong></td>
<td>Literature on Child Development <strong>Next Appointment</strong></td>
<td>Literature on Child Development <strong>Next Appointment</strong></td>
<td>Literature on Child Development <strong>Next Appointment</strong></td>
</tr>
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</table>
# RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

<table>
<thead>
<tr>
<th>AGES</th>
<th>FOUR MONTHS</th>
<th>SIX MONTHS</th>
<th>NINE MONTHS</th>
<th>TWELVE MONTHS</th>
</tr>
</thead>
</table>
| **NUTRITION and EXERCISE** | May introduce baby food slowly | Finger foods
Introduce cup use | Finger Foods/Self-feeding
Transition to cup | Nutrition/Self-feeding
Transition to cup |
| **DENTAL HEALTH** | Early dental decay | Teething /
Early dental decay | Early dental decay | Dental caries prevention |
| **ACCIDENT/INJURY PREVENTION** | Supine sleeping position
Injury prevention/
“Babyproofing”/
Safety with siblings and pets
Drowning prevention/
Sun safety
Car seat/Auto safety
“Shaken baby syndrome” | Supine sleeping position
Injury prevention/
“Babyproofing”
Safety with siblings and pets
Drowning prevention/
Sun safety
Car seat/Auto safety
“Shaken baby syndrome” | **Sleep practices**
Injury prevention/
“Babyproofing”/
Poison control no.
Safety with siblings and pets
Drowning prevention/
Sun safety
Car seat/Auto safety
“Shaken baby syndrome” | Sleep practices
“Babyproofing”/
Poison Control no.
Safety with siblings and pets
Drowning /
Sun safety
Car seat/Auto safety |
| **HEALTH AWARENESS/ SAFETY HABITS** | Signs of Illness
Emergency/911
Passive smoke
Parenting practices
“Safe at home”
Potential for abuse
Child care safety
Limit TV/Video exposure | Emergency/911
Passive smoke
Parenting advice
“Safe at home”
Potential for abuse
Child care safety
Limit TV/Video exposure | Emergency/911
Passive smoke
Parenting advice
“Safe at home”
Potential for abuse
Child care safety
Limit TV/Video exposure | **Time with parents/Reading**
Emergency/911
Passive smoke
“Safe at home”
Parenting advice
Potential for abuse
Child care safety
Limit TV/Video exposure
Time with parents/Reading |
| **PSYCHOSOCIAL ISSUES** | Postpartum adjustment
Family involvement
Parent/Infant attachment
Fears and phobias | Family involvement
Interactions with parents
Parental/Sibling adjustment
Fears and phobias | Family involvement
Interactions with parents
Stranger awareness
Sibling interactions
Parental adjustment
Family functioning | Stranger Awareness
Social Interactions/
Expectations
Sibling interactions
Family functioning
Parental adjustment |
| **FOR ADDITIONAL INFORMATION** | Literature on Child Development
Next Appointment | Literature on Child Development
Next Appointment | Literature on Child Development
Next Appointment | Literature on Child Development
Next Appointment |

Anticipatory Guidance, DSS, 2006
## RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

<table>
<thead>
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<th>AGES</th>
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<th>TWENTY FOUR MONTHS</th>
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<td>Nutrition/Exercise/Vitamins</td>
<td>Nutrition/Exercise/Vitamins</td>
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<td>Dental caries prevention</td>
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<td>Dental caries prevention/Dental care</td>
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<tr>
<td>ACCIDENT/INJURY PREVENTION</td>
<td>Sleep practices</td>
<td>Sleep practices</td>
<td>Injury prevention/“Childproofing”</td>
</tr>
<tr>
<td></td>
<td>Injury prevention/“Childproofing”</td>
<td></td>
<td>Poisonous plant awareness</td>
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<td>Drowning prevention/Sun safety</td>
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<td>Safety with siblings and pets</td>
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<td>Car seat/auto safety</td>
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<td>Drowning prevention/</td>
</tr>
<tr>
<td></td>
<td>Fire safety</td>
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<td>Sun safety</td>
</tr>
<tr>
<td></td>
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<td>Car seat/Auto safety</td>
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<td>Fire safety/Burns</td>
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<td>Violence prevention/</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Gun safety</td>
</tr>
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<td>HEALTH AWARENESS/SAFE</td>
<td>Emergency/911</td>
<td>Emergency/911</td>
<td>Emergency/911</td>
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<td>SAFETY HABITS</td>
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<td>“Safe at home”</td>
<td>“Safe at home”</td>
<td>“Safe at home”</td>
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<td>Potential for abuse</td>
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<td></td>
<td>Child care safety</td>
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<td>Time with parents/Reading</td>
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<td>Toilet training</td>
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<td>Read to child</td>
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<td>Limit TV/Video exposure</td>
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<tr>
<td>PSYCHOSOCIAL ISSUES</td>
<td>Sibling interactions</td>
<td>Sibling interactions</td>
<td>Family involvement</td>
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<td>Family functioning</td>
<td>Family functioning</td>
<td>Fears and phobias</td>
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<td>Parental adjustment</td>
<td>Parental adjustment</td>
<td>Peer companionship</td>
</tr>
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<td>Social interactions/Expectations</td>
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<td>Self control</td>
</tr>
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<td>Limit setting</td>
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<td>Sexual self-awareness</td>
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<tr>
<td>FOR ADDITIONAL INFORMATION</td>
<td>Literature on Child Development</td>
<td>Literature on Child Development</td>
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<tr>
<td></td>
<td>Next Appointment</td>
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### RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

<table>
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<th>FOUR YEARS</th>
<th>FIVE YEARS</th>
<th>SIX YEARS</th>
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<td><strong>Good</strong> nutrition/Exercise</td>
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<td><strong>DENTAL HEALTH</strong></td>
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</tr>
<tr>
<td><strong>PSYCHOSOCIAL ISSUES</strong></td>
<td>Family involvement Limits/Consequences Social interactions/Expectations Sexual self-awareness Peer companionship</td>
<td>Social interaction Family functioning Self control</td>
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<td>Social interaction Age-appropriate behavior Family functioning Self control</td>
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<td>Literature on Child Development Next Appointment</td>
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Anticipatory Guidance, DSS, 2006
## RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

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<td>Dental/ Flossing/Self care</td>
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<tr>
<td>ACCIDENT/INJURY PREVENTION</td>
<td>Drowning/Sun safety</td>
<td>Drowning/Sun safety</td>
<td>Drowning/Sun safety</td>
</tr>
<tr>
<td></td>
<td>Seat belt/Auto safety</td>
<td>Seat belt/Auto safety</td>
<td>Seat belt/Auto safety</td>
</tr>
<tr>
<td></td>
<td>Sport bike/Helmet use</td>
<td>Sport bike/Helmet use</td>
<td>Sport bike/Helmet use</td>
</tr>
<tr>
<td></td>
<td>Violence prevention/Gun safety</td>
<td>Violence prevention/Gun safety</td>
<td>Violence prevention/Gun safety</td>
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<td>HEALTH</td>
<td>Passive smoke</td>
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</tr>
<tr>
<td>AWARENESS/SAFETY HABITS</td>
<td>Parenting advice</td>
<td>Parenting advice</td>
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<td>“Safe at home”</td>
<td>“Safe at home”</td>
<td>“Safe at home”</td>
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<td>Potential for abuse</td>
<td>Potential for abuse</td>
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</tr>
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<td>Afterschool/Child care issues</td>
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<td>Sex education</td>
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<td>Limit TV/Video/Internet use</td>
<td>Limit TV/Video/Internet use</td>
<td>Limit TV/Internet use</td>
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<tr>
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<td>Tobacco/Alcohol/Drugs/Inhalants</td>
<td>Tobacco/Alcohol/Drugs/Inhalants</td>
<td>Tobacco/Alcohol/Drugs/Inhalants</td>
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<td>Peer refusal skills/Gangs</td>
<td>Peer refusal skills/Gangs</td>
<td>Peer refusal skills/Gangs</td>
</tr>
<tr>
<td>PSYCHOSOCIAL ISSUES</td>
<td>Social interaction</td>
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<td>Age-appropriate behavior</td>
<td>Family functioning</td>
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<td>Self control</td>
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<td>Self control</td>
<td>Depression/Anxiety</td>
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<td>Depression/Anxiety</td>
<td>Conflict resolution skills</td>
<td>Conflict resolution skills</td>
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<tr>
<td>FOR ADDITIONAL INFORMATION</td>
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<td>Literature on Child Development Next Appointment</td>
<td>Literature on Child/Adolescent Development Next Appointment</td>
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</table>
### RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

<table>
<thead>
<tr>
<th>AGES</th>
<th>13, 14 YEARS</th>
<th>15, 16, 17 YEARS</th>
<th>18, 19, 20 YEARS</th>
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<tbody>
<tr>
<td><strong>NUTRITION and EXERCISE</strong></td>
<td>Good nutrition/Exercise</td>
<td>Good nutrition/Exercise</td>
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<tr>
<td><strong>DENTAL HEALTH</strong></td>
<td>Dental/ Flossing/Self care</td>
<td>Dental/ Flossing/Self care</td>
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</tr>
<tr>
<td><strong>ACCIDENT/INJURY PREVENTION</strong></td>
<td>Drowning/Sun safety</td>
<td>Drowning/Sun safety</td>
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</tr>
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<td>Seat belt/Driving safety</td>
<td>Seat belt/Driving safety</td>
<td>Seat belt/Driving safety</td>
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<td>Sport bike/Helmet use</td>
<td>Sport bike/Helmet use</td>
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<td>Violence prevention/Gun safety</td>
<td>Violence prevention/Gun safety</td>
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<td><strong>HEALTH AWARENESS/ SAFETY HABITS</strong></td>
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<td>Parenting advice</td>
<td>Parenting advice</td>
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<td>Peer refusal skills/Gangs</td>
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<td><strong>PSYCHOSOCIAL ISSUES</strong></td>
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<td><strong>Special Needs: Transition planning (start at age 16)</strong></td>
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<td><strong>FOR ADDITIONAL INFORMATION</strong></td>
<td>Literature on Child/Adolescent Development</td>
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<td>Next Appointment</td>
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<td>Transition to Internist/ Family Practice/GP</td>
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*Anticipatory Guidance, DSS, 2006*