NEVADA HEALTHY KIDS (EPSDT)/WELL BABY/WELL CHILD

Initial New Patient Screening Form (CPT 99381-99385)

Name_____ **Date** _____**DOB** _____**Age** _____**Sex**_____

Medicaid# _____**Parent/Guardian Name** _____**Provider NPI**_____

Patient's Medical History

Birth Weight_____ **Birth Length** _____**Serious Injury/Illness**_____**Surgeries**_____

Menarch/Sexual History (if applicable) _____ **Behavioral/Emotional History**_____

Family Medical History (Check disease & indicate family member with the problem: **P**-parent **G**-grandparent **B**-Brother, **S**-Sister)

Asthma/Allergies _____	**Heart Attack/Stroke**_____	**Scoliosis/Arthritis**_____	**Retardation**_____
Birth Defects_____	**High Blood Pressure**_____	**Substance Abuse**_____	**Mental Illness**_____
Blood/Sickle Cell_____	**Kidney/Liver Disease**_____	**Urinary Problems**_____	**Disabilities**
Cancer_____	**Lung Disease**_____	**Ulcers/Stomach Upset**_____	**Other**_____
Diabetes_____	**Obesity**_____	**Bowel Problems**_____	_____

Growth/Vital Signs

Ht_____ **(**_____ **%)** **Temp**_____ **Pulse**_____ **Resp**_____ **B/P**_____ **Allergies**_____

Wt_____ **(**_____ **%)** **Current Medications**_____**Nutrition**_____

HC or BMI_____ **(**_____ **%)** **Present Concerns**_____

Physical Exam-unclothed (**N**- Normal **A**- Abnormal **NE**- No exam)

N	A	NE		N	A	NE		N	A	NE	
____	____	____	**Appearance**	____	____	____	**Nose**	____	____	____	**Abdomen**
____	____	____	**Head/Face**	____	____	____	**Mouth/Teeth**	____	____	____	**Genitalia**
____	____	____	**Hair/Scalp**	____	____	____	**Neck**	____	____	____	**Musculoskeletal**
____	____	____	**Eyes/Vision Screen**	____	____	____	**Heart/Lungs**	____	____	____	**Extremities**
____	____	____	**Ears/Hearing Screen**	____	____	____	**Skin/Nodes**	____	____	____	**Neuro**

Describe any abnormalities_____

Developmental/Emotional Behavior

Age/Culturally appropriate (i.e. through parental interview, observation or screening tool): _____ **Yes** _____ **No**

Name of screening tool, if used: _____ **Referral:** _____

Anticipatory Guidance/Nutrition/Safety (Check each one that is discussed with patient/caregiver.)

_____ **Nutrition**	_____ **Adequate Sleep**	_____**Limit TV/Computer Time**	_____**Maternal/Caregiver Depression**
_____ **Vitamins**	_____ **Active Play**	_____ **Social/School Adjustment**	
_____ **Brush Teeth/Visit Dentist**	_____ **No Smoking in House/Car**	_____ **Privacy/Hygiene**	
_____ **Family Relationships**	_____ **Car Seat/Safety Belt**	_____ **Puberty/Sex**	

Impression

Well Child ____**Yes** ____ **No Dx:** _____ **Normal Growth/Development** ____**Yes** ____**No Dx:** _____ **Next screening due**_____

Treatment/Plan/Referral

_____ **Fluoride Varnish Application** _____ **Refer to dentist** _____**Refer to Specialist** **Type of Specialist**_____

Immunizations Given _____ Up-to-date

_____ **DTaP** (DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td)	_____ **MMR**(MMR, MMRV)
_____ **Hib** (Hib, Hib-HepB, DTaP-Hib)	_____ **Meningococcal** (MCV4, MPSV4)
_____ **Hep A**	_____ **Pneumococcal** (PCV, conjugate, PPV, polysaccharide)
_____ **Hep B** (HepB, Hib-HepB, DTap-HepB-IPV)	_____ **Polio** (IPV, DTaP-HepB-IPV)
_____ **HPV**	_____ **Rotavirus**
_____ **Influenza** (TIV, LAIV)	_____ **Varicella** (Var, MMRV)

Laboratory Ordered _____Up-to-date

_____ **Hemoglobin/Hematocrit**	_____ **Lead Testing**	_____ **PKU**	
_____ **Sickle Cell**	_____ **TB Test**	_____ **U/A**	_____ **Other**_____

Provider Signature: _____ **Date:** _____