

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 _____
Menarche/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: _____