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

Established Patient Screening Form (CPT 99391-99395)

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

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

Patient's Medical History

History reviewed from last visit. ____No ____Yes Any changes since last visit? ____No ___Yes_____

Family Medical: ____Refer to completed history form in chart. Updates? _____

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**	_____ **Pool/Water Safety**
_____ **Brush Teeth/Visit Dentist**	_____ **No Smoking in House/Car**	_____ **Privacy/Hygiene**	_____ **Bike/Helmet Safety**
_____ **Family Relationships**	_____ **Car Seat/Safety Belt**	_____ **Puberty/Sex**	

Impression

Well Child ____Yes ____No Dx: _____ **Normal Growth/Development ____Yes ____No Dx:** _____ **Next visit 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:** _____