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/. 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.
**Well Care Exam (EPSDT) Form**

### Date of Care: 2 – 14 Day Old

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

**Accompanied by:**

**Allergies:** □ NKA ____________

**Current Medication(s):**

**Weight:** ____________

**Percentile:** ____________

**Height:** ____________

**Percentile:** ____________

**Head Circ:** ____________

**Percentile:** ____________

### 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?**

<table>
<thead>
<tr>
<th>Normal</th>
<th>Describe abnormal findings:</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
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<tr>
<td>No</td>
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</tbody>
</table>

- **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**
- 2nd Newborn PKU (>72 hrs)
- Prenatal labs/history

### 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 ____________

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*Update 1-06*
**Well Care Exam (EPSDT) Form**

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<tr>
<th>Date</th>
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<th>Age</th>
<th>Proc. code – circle one</th>
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<td>99381-New, 99391-Estab</td>
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</tbody>
</table>

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

**Weight:** ____________ **Percentile:** ____________ **Height:** ____________ **Percentile:** ____________ **Head Circ:** ____________ **Percentile:** ____________

**HISTORY:**

**Parental Comments/Concerns:**

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

**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**

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<thead>
<tr>
<th>Are the following normal?</th>
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<td>Ear/Hearing</td>
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<td>(Hospital screening done?)</td>
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<tr>
<td>Neurological</td>
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</tbody>
</table>

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

| Was Hepatitis B given at birth? | Yes ______ | No ______ |
| Shot Record initiated?         | Yes ______ | No ______ |

**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:** [ ] 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
## Well Care Exam (EPSDT) Form

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### Accompanied by: Allergies: □ NKA ____________ Current Medication(s)

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<th>Weight:</th>
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<th>Percentile:</th>
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</thead>
</table>

### HISTORY:

**Temp:**

**Pulse:**

**Resp:**

### Parental Comments/Concerns:

**Fluoride checked?**

(if well water)

### 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?**

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<td>Neurological</td>
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</tr>
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### ASSESSMENT & PLAN:

### IMMUNIZATIONS:

**Pt. needs immunizations?**

Yes _____ No _____ Delayed? _____ Deferred? _____

**Given today?**

- Hep B _____
- DTaP _____
- IPV _____
- Hib _____
- PCV _____
- Other _____

### 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

Update 1-06

**Bold** = First asked this age
**4 Month Old**

**Well Care Exam (EPSDT) Form**

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**Accompanied by:**

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

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<th>Percentile:</th>
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</thead>
</table>

**HISTORY:**

**Parental Comments/Concerns:**

**Nutritional Screen:**  
Breast Feeding:  
Formula (type):  
Fluoride checked?  
(If well water)

**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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<th>Skin/Hair/Nails</th>
<th>Ear/Hearing (Hospital screening done?)</th>
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<th>Back/Hips</th>
<th>Neurological</th>
</tr>
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</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

**Date Consult Report Received:**

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

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

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**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:  

**SCREENINGS:**

- Eyes/Vision: Verbal Lead Risk Assessment  
- Mouth/Throat/Teeth: Yes/ No  
- Nose/Head/Neck:  
- Heart:  
- Lungs:  
- Abdomen:  
- Genitourinary:  
- Extremities:  
- Back/Hips:  
- Neurological:  

**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  
- “Shaken baby syndrome”  
- Injury prevention/ “Baby - proofing”  
- Safety with siblings and pets  
- Drowning prevention/ Sun safety  
- Car seat/Auto safety  
- 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
### 9 Month Old Well Care Exam (EPSDT ) Form

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<tr>
<th>Date</th>
<th>Last Name:</th>
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<td>99381-New, 99391-Estab</td>
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</tbody>
</table>

Accompanied by: | Allergies: □ NKA | Current Medication(s): |
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<th>Weight:</th>
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<th>Head Circ:</th>
<th>Percentile:</th>
<th>BMI:</th>
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**HISTORY:**

Parental Comments/Concerns:

Dental Screen: Brushing teeth? Yes No Education re: Limit sugar intake/give healthy snacks? Yes No

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

**PHYSICAL EXAM**

Are the following normal? Normal Describe abnormal findings:

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

**LABS ORDERED:**

- Tuberculin Test (perform if at risk)
- Blood lead test/ referral (or perform at 1 year)

**Behavioral/Developmental Screen**

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

**ASSESSMENT & PLAN:**

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

Given today? Hep B Hib DTap PCV Influenza IPV Other

**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
"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:**

- WIC
- Birth to Three
- Dental
- 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

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Accompanied by: Allergies: □ NKA ______________ | Current Medication(s) |

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## History:

Parental Comments/Concerns:

Dental Screen:

Nutritional Screen:

### Physical Exam

<table>
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<tr>
<th>Are the following normal?</th>
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<th>LABS ORDERED:</th>
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<tr>
<td>Skin/Hair/Nails</td>
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<td></td>
<td>Tuberculin Test</td>
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<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>Verbal Lead Risk Assessment</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
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<td></td>
<td>Blood lead test/referral (if not done at 9 mos.)</td>
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<td>Nose/Head/Neck</td>
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### Assessment & Plan:

**Immunizations**

Pt. needs immunizations?

Anticipatory Guidance Provided:

- Nutrition/Self-feeding
- Transition to cup
- Dental caries prevention
- Sleep practices
- "Babypoofing"/Poison Control 
- Safety with Siblings and Pets

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): ________________

Weight: ________________ Height: ________________ Head Circ: ________________ BMI: ________________

**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: 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:**

Pt. needs immunizations? Yes No Delayed? Deferred? Influenza

Given today? Hep B DTaP Hib IPV MMR Varicella PCV

**ANTICIPATORY GUIDANCE PROVIDED**

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

- Fire 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

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

Update 1-06

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

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<th>Date</th>
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<th>First Name:</th>
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<th>Age</th>
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</tbody>
</table>

- 99382-New, 99392-Estab

Accompanied by: [ ]

Allergies: [ ] NKA ______________ Current Medication(s): ______________

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

**HISTORY:**

Temp: ____________ Pulse: ____________ Resp: ____________

**Parental Comments/Concerns:**

Fluoride checked? (if well water) ____________

**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:**

- Tuberculin Test
- Verbal Lead Risk Assessment
- Blood lead test (if not previously done)

Additional Labs Ordered:

- Hgb/Hct (HRisk/WIC) ____________
- Urinalysis ____________
- Other: ____________

**Behavioral/Developmental Screen**

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

**ASSESSMENT & PLAN:**

**IMMUNIZATIONS:**

Pt. needs immunizations? Yes  No  Delayed?  Deferred?  

- Given today? DTaP ______ Varicella ________ Influenza ______ HIB ______ Other ______

**ANTICIPATORY GUIDANCE PROVIDED**

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

**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.
24 Month Old

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: 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

Are the following normal? Normal Describe abnormal findings:

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

LABS ORDERED:

Tuberculin Test
(perform if at risk)

Verbal Lead Risk Assessment
Blood lead test referral

Additional Labs Ordered:
Hgb/Hct (HRisk/WIC)
Urinalysis
Other:

Behavioral /Developmental Screen
Home Environment
General Screen (e.g. PEDS or other tool)
Activities (risk level)

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
Family involvement
Fears and Phobias
Peer Companionship
Self control
Sexual self-awareness
Next appointment

Speech
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
- Fluoride checked?

Parental Comments/Concerns:

### Dental Screen:
- Date of Last exam/referral:
- Next appt: Routine Urgent Parent advised
- Brushing child’s teeth?

### 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:

<table>
<thead>
<tr>
<th>Skin/Hair/Nails</th>
<th>Tuberculin Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Hearing</td>
<td>Verbal Lead Risk Assessment</td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td>Blood lead test (If not done at age 24 months)</td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td>Additional Labs Ordered:</td>
</tr>
<tr>
<td>Nose/Head/Neck</td>
<td>Hgb/Hct (HRisk/WIC)</td>
</tr>
<tr>
<td>Lungs</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>Heart</td>
<td>Other:</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Behavioral /Developmental Screen</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>❑ Home Environment</td>
</tr>
<tr>
<td>Extremities</td>
<td>❑ General Screen (e.g. PEDS or other tool)</td>
</tr>
<tr>
<td>Back/Hips</td>
<td>❑ Activities (risk level)</td>
</tr>
<tr>
<td>Neurological</td>
<td>❑ School Readiness</td>
</tr>
</tbody>
</table>

#### Labs Ordered:
- Additional Labs Ordered:
- Hgb/Hct (HRisk/WIC)

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

### IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Hep A</th>
<th>Hep B</th>
<th>Varicella</th>
<th>PCV</th>
</tr>
</thead>
</table>

#### Anticipatory Guidance Provided

- Nutrition/ exercise/ vitamins
- Car Seat /Auto safely
- “Safe at home?”

- Dental care
- Sport bike/helmet use
- Potential for abuse

- 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

Update 1-06

**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 – <strong>circle one</strong></th>
<th>99382-New, 99392-Estab</th>
</tr>
</thead>
</table>

Accompanied by:  

Allergies: NKA:  

Current Medication(s):  

<table>
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<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:  

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:  

Skin/Hair/Nails  

Tuberculin Test  

(perform if at risk)  

Ear/Hearing  

Verbal Lead Risk  

Assessment  

Eyes/Vision  

Blood lead test (if not done since age 1)  

Mouth/Throat/Teeth  

Additional Labs Ordered:  

Nose/Head/Neck  

Hgb/Hct (HRisk/WIC)  

Urinalysis  

Other:  

Genitourinary  

Behavioral/Developmental Screen  

Extremities  

General Screen (e.g. PEDS or other tool)  

Abdomen  

Activities (risk level)  

Back/Hips  

School readiness  

Neurological  

ASSESSMENT & PLAN: (Confidential Documentation attached)

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

**ANTICIPATORY GUIDANCE PROVIDED**  

- Good nutrition/Exercise  
- Dental care  
- Drowning/Sun Safety  
- Car Seat/Auto safety  
- "Safe at home?"  
- "Potential for abuse"  
- "Child Care Safety"  
- "Violence prevention/Gun safety"  
- "Fire Safety"  
- "Toileting Habits"  
- "Reading to child/ Preschool"  
- "Passive Smoke"  
- "Limit TV/Internet Use"  
- "Social Interaction"  
- "Family functioning"  
- "Self Control"  
- "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**
**Well Care Exam (EPSDT) Form**

<table>
<thead>
<tr>
<th>Date</th>
<th>Last Name:</th>
<th>First Name:</th>
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<th>Age</th>
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Accompanied by: ___________________________

Allergies: NKA: __________

Current Medication(s): __________________

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<th>Height:</th>
<th>Percentile:</th>
<th>BMI:</th>
<th>Percentile:</th>
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**HISTORY:**

Vision Exam

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<th>Pulse:</th>
<th>Resp:</th>
<th>BP</th>
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<td>OU</td>
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Corrected / uncorrected Fluoride checked?

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<th>Current Medication(s)</th>
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</table>

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)

Hearing Screen: Within normal limits? (Audiometry)

<table>
<thead>
<tr>
<th>Hearing Screen</th>
<th>Yes</th>
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**PHYSICAL EXAM**

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

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<tr>
<th>Skin/Hair/Nails</th>
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Ear/Hearing

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Mouth/Throat/Teeth

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Nose/Head/Neck

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<table>
<thead>
<tr>
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<th>Normal</th>
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<table>
<thead>
<tr>
<th>Abdomen</th>
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<table>
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<tr>
<th>Genitourinary</th>
<th>Normal</th>
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<table>
<thead>
<tr>
<th>Extremities</th>
<th>Normal</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Back/Hips</th>
<th>Normal</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Neurological</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Anticipatory Guidance Provided:</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Good nutrition/Exercise</td>
<td>Sports/injury prevention</td>
<td>Child Care Safety</td>
</tr>
<tr>
<td>Dental care</td>
<td>Violence prevention/Gun safety</td>
<td>Toileting Habits</td>
</tr>
<tr>
<td>Drowning/Sun Safety</td>
<td>Fire Safety</td>
<td>Reading to child/School readiness</td>
</tr>
<tr>
<td>Car Seat /Auto safely</td>
<td>Passive Smoke</td>
<td>Limit TV/Video/Internet Use</td>
</tr>
<tr>
<td>Sport bike/Helmet use</td>
<td>“Safe at home?”</td>
<td></td>
</tr>
</tbody>
</table>

**REFERRALS:**

<table>
<thead>
<tr>
<th>WIC</th>
<th>Behavioral</th>
<th>Dental</th>
<th>Nutritional</th>
<th>Speech</th>
<th>Specialty</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Date Consult Report Received:</th>
</tr>
</thead>
</table>

Clinician Name (print) ___________

Clinician Signature Yes ______ No ______

*Update 1-06*

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

<table>
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<th>Date</th>
<th>Last Name:</th>
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<th>Age</th>
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<th>circle one</th>
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<td></td>
<td></td>
<td></td>
<td>99383-New</td>
<td>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>
</tr>
</thead>
</table>

**HISTORY:**  
Vision Exam (if needed @):  
OD  
OS  
OU  
Temp:  
Pulse:  
Resp:  
BP  
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: _______  

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**

<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>
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<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
<td>Blood lead test (perform once, at age up to 72 months)</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</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td>Urinalysis</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 (or substitute GAPS or other tool):</td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td>❑ Home Environment</td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
<td>❑ Activities (risk level)</td>
</tr>
<tr>
<td>Back/Hips</td>
<td></td>
<td></td>
<td>❑ General Screen (e.g. PEDS or other)</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>❑ School Attendance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>❑ School Performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>❑ Social Interactions</td>
</tr>
</tbody>
</table>

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

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>MMR</th>
<th>Varicella</th>
<th>Hep B</th>
<th>DTaP</th>
<th>IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td></td>
</tr>
</tbody>
</table>

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

**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** | **Last Name:** | **First Name:** | **Date of Birth** | **Age** | **Proc. code**
---|---|---|---|---|---

<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 ______

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

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

**Physical Activity:**

**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 ______</td>
</tr>
<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></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
<td></td>
<td>Behavioral/Developmental Screen</td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
<td>❑ Home ❑ Activities (risk level)</td>
</tr>
<tr>
<td>Back/Hips</td>
<td></td>
<td></td>
<td>❑ General Screen (e.g. PEDS or other)</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>❑ School ❑ School Performance Attendance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>❑ Social Interactions</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>Influenza</td>
<td>Other</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

- Sex Education
- Sports/Injury prevention
- Violence prevention/Gun safety
- "Safe at home?"
- Afterschool/Child Care Issues

- Self Control
- Depresssion/Anxiety
- Limit TV/Video/Internet Use
- Tobacco/Alcohol/Drugs/Inhalants
- Social Interaction
- Parenting advice
- Family Functioning

**REFERRALS:**

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

**Date Consult Report Received:**

**Clinician Name (print)** | **Clinician Signature** | **Yes** | **No**

*Update 1-06*

*Bold = First asked this age range*
Date | Last Name: | First Name: | Date of Birth | Age | Proc. code—circle one
---|---|---|---|---|---
|  |  |  |  |  | 99383-New 99393-Established
Accompanied by: | Allergies:NKAD | Current Medication(s) |  |  |  

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: 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? 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**

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

**IMMUNIZATIONS**

Given Today: Hep B Td MMR

Varicella □ □ Hep A □ □ Influenza □ □ Other □ □

**ANTICIPATORY GUIDANCE PROVIDED**

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

**REFERRALS:** □ Behavioral □ Dental □ Nutritional □ OB/GYN □ 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
**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] 99384-New, 99394-Estab age 12 99383-New, 99393-Estab age 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accompanied by:</td>
<td>Allergies: NKA</td>
<td>Current Medication(s)</td>
<td></td>
<td></td>
</tr>
</tbody>
</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

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: ________

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

Hearing Screen: Within normal limits? ____________

**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/Breast</td>
<td>Normal</td>
<td>Describe abnormal findings:</td>
</tr>
<tr>
<td>Pelvic Exam/STD Screening (if appropriate)</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:**

- Tuberculin Test
- Hgb/Hct
- Urinalysis
- Lipid profile
- Behavioral Screen (or substitute GAPS or other tool):
  - Home Environment
  - Activities (risk level)
  - Educational Goals
  - Depression/Suicide
  - Sexual Activity
  - Drugs/Alcohol
  - Other Tests:

**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>
<th>Other</th>
</tr>
</thead>
</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/Anxiety
- Conflict resolution skills
- Parenting advice)
- Next appointment

**REFERRALS:**

- Behavioral
- Dental
- Nutritional
- OB/GYN
- 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**
### 13, 14 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>
<th>99384-New, 99394-Estab</th>
</tr>
</thead>
</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 (if needed)</th>
<th>OD</th>
<th>OS</th>
<th>OU</th>
</tr>
</thead>
</table>

Corrected / uncorrected

#### 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)  
  Yes  
  No

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

#### PHYSICAL EXAM

**Are the following normal?**  
Normal  
Describe abnormal findings:

<table>
<thead>
<tr>
<th>LABS ORDERED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculin Test</td>
</tr>
</tbody>
</table>

(perform if at risk)

<table>
<thead>
<tr>
<th>Heart</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Genitourinary/Breast</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pelvic Exam/STD Screening (if appropriate)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Extremities</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Back/Hips</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
</tr>
</thead>
</table>

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

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Given Today:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Varicella</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hep B</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Td</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MMR</th>
</tr>
</thead>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**

<table>
<thead>
<tr>
<th>Good nutrition/Exercise</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sports/injury prevention</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Violence prevention/Sun safety</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parenting advice</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>“Safe at home?”</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Social Interaction</th>
</tr>
</thead>
</table>

**REFERRALS:**

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

<table>
<thead>
<tr>
<th>Date Consult Report Received:</th>
</tr>
</thead>
</table>

**Date Consult Report Received:**

**See Additional/Supervisory Note?**

Yes  
No

**Clinician Name (print):**

**Clinician Signature:**

**Update 1-06**

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

**Date** | **Last Name:** | **First Name:** | **Date of Birth** | **Age** | **Proc. code –circle one**
--- | --- | --- | --- | --- | ---

99384-New, 99394-Estab

**Accompanied by:**

**Allergies:** NKA:

**Current Medication(s):**

**Weight:** | **Percentile:** | **Height:** | **Percentile:** | **BMI:** | **Percentile:**
--- | --- | --- | --- | --- | ---

**HISTORY:**

Vision Chart Exam-age 15

**Temp:**

**OD**

**Pulse:**

**OS**

**Resp:**

**OU**

**BP**

**Corrected / uncorrected**

**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**

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

**ASSESSMENT & PLAN:**

(Confidential Documentation attached)

**IMMUNIZATIONS**

Given Today: Hep B _____ Td _____ MMR _____

**Varicella**

**Hep A**

**Influenza**

**Other**

**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/Axiety
- Conflict resolution skills
- Transition Planning (age 16 on)
- Next appointment

**REFERRALS:**

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

**Date Consult Report Received:**

**See Additional/Supervisory Note?**

**Clinician Name (print)**

**Clinician Signature**

Yes _____ No _____

*Update 1-06*

*Bold = First asked this age range*
**18, 19, 20 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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99385-New, 99395-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 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**  
Are the following normal?  
Normal  
Describe abnormal findings:  

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

<table>
<thead>
<tr>
<th>Eyes/Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
</tr>
<tr>
<td>Urinalysis</td>
</tr>
<tr>
<td>Lipid profile</td>
</tr>
<tr>
<td>(perform if at risk)</td>
</tr>
</tbody>
</table>

**Other Tests:**  

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

**IMMUNIZATIONS**  
Given Today:  

<table>
<thead>
<tr>
<th>Varicella</th>
<th>Hep A</th>
<th>Influenza</th>
<th>Td</th>
<th>MMR</th>
<th>Other</th>
</tr>
</thead>
</table>

**ANTICIPATORY GUIDANCE PROVIDED**  

<table>
<thead>
<tr>
<th>Good nutrition/Exercise</th>
<th>Sports/Injury prevention</th>
<th>Educational goals/Activities</th>
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<td>Dental/Flossing/Self care</td>
<td>Violence prevention/Gun safety</td>
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<td>Peer refusal skills</td>
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**REFERRALS:**  

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**Clinician Name (print):**  
**Clinician Signature:**  

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<td>See Additional/Supervisory Note?</td>
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**Update 1-06**  
**Bold = First asked this age range**
### RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

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<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>
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# RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

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<td>Postpartum adjustment Family involvement Parent/Infant attachment Fears and phobias</td>
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<td>Stranger Awareness Social Interactions/ Expectations Sibling interactions Family functioning Parental adjustment</td>
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Anticipatory Guidance, DSS, 2006
## RECOMMENDATIONS FOR ANTICIPATORY GUIDANCE

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

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

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<td>Parenting advice&lt;br&gt;“Safe at home”&lt;br&gt;Sexual Education/Counseling&lt;br&gt;Breast/Testicular Self Exam&lt;br&gt;Education goals/Activities&lt;br&gt;Limit TV/Internet Use&lt;br&gt;Tobacco/Alcohol/Drugs/Inhalants&lt;br&gt;Peer refusal skills/Gangs</td>
<td>Parenting advice&lt;br&gt;“Safe at home”&lt;br&gt;Sex Education/Counseling&lt;br&gt;Breast/Testicular self exam&lt;br&gt;Education goals/Activities&lt;br&gt;Limit TV/Internet Use&lt;br&gt;Tobacco/Alcohol/Drugs/Inhalants&lt;br&gt;Peer refusal skills</td>
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<td>Social interaction&lt;br&gt;Family functioning&lt;br&gt;Self control&lt;br&gt;Depression/Anxiety&lt;br&gt;Conflict resolution skills&lt;br&gt;<strong>Special Needs: Transition planning (start at age 16)</strong></td>
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