



# KAN Be Healthy (EPSDT) Screening Form

I.D. Number: \_\_\_\_\_

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name _____	Date of Birth _____	Age _____	Date of Screen _____
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## PHYSICAL GROWTH

T _____	Weight _____ (lbs/kg) _____ th%	Weight/Length _____ %	Head Circ (≤ 24 months) _____ cm/in
P _____	Length (Birth to 24 months) _____ cm/in	Standing Height (2 - 20 years) _____ cm/in	
R _____	BMI _____ th%		
BP _____	BMI ≥ 85%: recommend appropriate nutrition input and physical activity.		
	Update Growth Chart (required at each screen)	Male <input type="checkbox"/>	_____ th%
		Female <input type="checkbox"/>	

## BENEFICIARY & FAMILY HISTORY

<input type="checkbox"/> Refer to completed history form in chart. <input type="checkbox"/> No changes in medical Hx unless indicated. <input type="checkbox"/> Previous Hx reviewed from _____ visit. <input type="checkbox"/> Patient currently in Foster care, no previous hx available.	Present Concern: _____ _____ _____ Medications: _____ Serious Illness/Accidents: <input type="checkbox"/> No <input type="checkbox"/> Yes (date & type) (including Hospital or ER visits) _____ Allergies (food & drug) _____ Birth History (Length, weight, complications, etc. - if known) _____ Operations: <input type="checkbox"/> No <input type="checkbox"/> Yes (date & type)
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(Circle and indicate the relationship with disease / problem. P-Parent, G-Grandparent, B-Brother, S-Sister, Self)

Allergies (food & drug) _____	Drug or ETOH Abuse _____	Mental Illness _____
Asthma _____	Earaches _____	Obesity _____
Birth defects _____	Epilepsy/Seizures _____	Scoliosis/Arthritis _____
Blood Disorder/ Sickle Cell _____	Headache _____	Speech, Visual, Hearing _____
Cancer _____	High Blood Pressure _____	Ulcers/Colitis _____
Colds/sore throat _____	Kidney/Liver Disease _____	Urinary/Bowel _____
Diabetes _____	Lung Disease _____	Heart Disease/Stroke _____

## BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head-Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes/Ears/Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral/Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	Lung sounds?
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Murmur?
Abdomen/Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Tanner Score (as appropriate): _____ Evaluate for excessive menstrual bleeding _____ Enuresis _____
Trunk / Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Vision Screen

<b>Ages 0 to 3 yr - Corneal Light Reflex Present:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ages 3 yr thru 20 - Bruckner Exam:</b> Pass <input type="checkbox"/> Refer <input type="checkbox"/> <b>All ages - Outer Inspection:</b> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> <b>Eye Tracking:</b> Pass <input type="checkbox"/> Refer <input type="checkbox"/> PERRLA: Pass <input type="checkbox"/> Refer <input type="checkbox"/> <b>Ocular Motility (strabismus/cross cover test):</b> Pass <input type="checkbox"/> Refer <input type="checkbox"/>	<b>Ages 3 thru 20:</b> <b>Distance Acuity -</b> _____ <b>Near Acuity -</b> _____ Tool used: _____ Tool used: _____ Score: L _____ R _____ Both _____ Score: L _____ R _____ Both _____ <b>Last exam:</b> _____ <b>Further comments (see below)</b> _____
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### NUTRITION

<input type="checkbox"/> WIC participant	
<input type="checkbox"/> Referred to WIC	
<input type="checkbox"/> Breast Feeding	<input type="checkbox"/> Formula
Amount & how often: _____	
Number of Servings per day	
Bread/Cereal _____	Dairy _____
Fat/Sweet/Sugar _____	Fruit _____
Meat/Bean/Egg _____	Vegetable _____
Fluid Intake: water _____ oz.	Soda _____
Milk _____ oz.	Juice _____

### PHYSICAL ACTIVITY

<input type="checkbox"/> Biking	<input type="checkbox"/> Basketball	<input type="checkbox"/> play outside
<input type="checkbox"/> Skating	<input type="checkbox"/> Walking	<input type="checkbox"/> other sports
How many hours screen time/Day? (i.e. TV, Games, PC)		
<input type="checkbox"/> 0-1 hr	<input type="checkbox"/> 1-2hr	<input type="checkbox"/> 3-5hrs <input type="checkbox"/> 5+hrs
<b>KBH participant currently pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes", then complete following :		
1. Prenatal Record initiated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. On prenatal vitamins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Referred for OB/GYN cares?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Referred to: _____		

### LABORATORY

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes  No  Indicate further follow-up in Plan of Care.

### DEVELOPMENTAL / EMOTIONAL

*Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.*  
**Children < 6 yrs.** A completed developmental screening tool to include the screener's interpretation and report regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care.

**Children 6-21 yrs.** A completed developmental screening tool to include the screener's interpretation and report or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care.

Developmental Tool used: \_\_\_\_\_

Sleep Habits _____	Tired / overactive? _____
Discipline: _____	Vocational concerns? _____
Peer Interaction: _____	Exercise _____
Grade Level _____	Average Marks _____
Special Education: _____	Special Needs: _____
Any emotional or behavioral problems? _____	
Emotional Observations: _____	

### IMMUNIZATIONS

Copy of record in chart	Current <input type="checkbox"/>	Needs (circle): Rota HepB DTaP Flu Hib IPV MMR MCV4 MPSV4 PCV Varicella HepA HPV Other: _____
	Behind <input type="checkbox"/>	
	Unknown <input type="checkbox"/>	
	Requested from Parent <input type="checkbox"/>	
Referred to VFC provider <input type="checkbox"/>		

### DENTAL

Sees Dentist? Yes  No   
 Last dental exam date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 # times brushes/day: \_\_\_\_\_  
 Dental Referral (annually at a minimum 1-20yr)  
 Yes  No  ~ Fluoride Varnish? Yes  No

### HEARING SCREEN

Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report.  
 Age birth to 4, perform Risk Indicators for Hearing Loss and Hearing Developmental Scales Pass  Refer   
 Hearing Health History >4: Pass  Refer   
 Or Screen Procedure: \_\_\_\_\_

### HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Circle Those Reviewed/ Handouts Given

1. Behavior/Discipline	5. Family Planning	9. Parenting	13. Self Breast Exam
2. Oral /Dental	6. Immunizations	10. Safety/Poisons	14. Sexuality
3. Development	7. Lifestyle	11. Substance Abuse	15. Exercise
4. Physical Activity	8. Nutrition	12. Self Testicular Exam	16. Weapon Safety
17. Other: _____			

### RESULTS/PLAN OF CARE

Screening Results: _____	Recommended Return Date: _____
Plan/Referrals (dental, vision, hearing, dietary, etc): _____	Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes <input type="checkbox"/> No <input type="checkbox"/> Parent/Caregiver and/or Patient Signature: _____ Date: _____
Screening Providers Signature: _____	



## Mandatory Blood Lead Screening Questionnaire

**To be completed at each KBH Screen from 6 to 72 months**

Does your child: (circle response received)	DATE: (MM/DD/YYYY)									
1) Live in or visit a house or apartment built before 1960? (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
2) Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
3) Have a family member with an elevated blood lead level?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
4) Interact with an adult whose job or hobby involves exposure to lead? (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
5) Live near a lead smelter, battery plant or other lead industry? (Ammunition/explosives, auto repair/auto body, cable/wiring stripping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	No	No	No	No	No	No	No	No	No	
One positive response to the above questions requires a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?										
Interviewing Staff Initials										
Staff Signature:										

Patient Name: \_\_\_\_\_

I.D. Number: \_\_\_\_\_