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

PHYSICAL GROWTH

T _____ **Weight** _____ (lbs/kg) _____ th% **Weight/Length** _____ %

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 ☐ **Female** ☐

Head Circ (≤ 24 months) _____ cm/in _____ th%

BENEFICIARY & FAMILY HISTORY

☐ Refer to completed history form in chart.

☐ No changes in medical Hx unless indicated.

☐ Previous Hx reviewed from _____ visit.

☐ Patient currently in Foster care, no previous hx available.

Present Concern: _____

Medications: _____

Serious Illness/Accidents: ☐ No ☐ Yes (date & type)

(including Hospital or ER visits)

Allergies (food & drug) _____

Birth History (Length, weight, complications, etc. - if known)

Operations: ☐ No ☐ Yes (date & type)

(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	☐	☐	
Integumentary	☐	☐	
Head-Neck	☐	☐	
Eyes/Ears/Nose & Throat	☐	☐	
Oral/Dental	☐	☐	
Pulmonary	☐	☐	Lung sounds?
Cardiovascular	☐	☐	Murmur?
Abdomen/Gastrointestinal	☐	☐	
Genitourinary	☐	☐	Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis
Trunk / Spine	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

Vision Screen

Ages 0 to 3 yr - Corneal Light Reflex Present: Yes ☐ No ☐
Ages 3 yr thru 20 - Bruckner Exam: Pass ☐ Refer ☐
All ages - Outer Inspection: Normal ☐ Abnormal ☐
Eye Tracking: Pass ☐ Refer ☐ PERRLA: Pass ☐ Refer ☐
Ocular Motility(strabismus/cross cover test): Pass ☐ Refer ☐

Ages 3 thru 20:
.Distance Acuity - Tool used:_____ Score: L____ R____ Both____
Near Acuity - Tool used: _____ Score: L____ R____ Both____
Last exam:_____ Further comments (see below)

NUTRITION

☐ WIC participant
☐ Referred to WIC
☐ Breast Feeding ☐ 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

☐ Biking ☐ Basketball ☐ play outside
☐ Skating ☐ Walking ☐ other sports
How many hours screen time/Day? (i.e. TV, Games, PC)
☐ 0-1 hr ☐ 1-2hr ☐ 3-5hrs ☐ 5+hrs

KBH participant currently pregnant? ☐ Yes ☐ No
If "yes", then complete following :
1. Prenatal Record initiated? ☐ Yes ☐ No
2. On prenatal vitamins? ☐ Yes ☐ No
3. Referred for OB/GYN cares? ☐ Yes ☐ 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 ☐
Behind ☐
Unknown ☐
Requested from Parent ☐
Referred to VFC provider ☐

Needs (circle): Rota
HepB DTaP Flu
Hib IPV MMR
MCV4 MPSV4 PCV
Varicella HepA HPV
Other:

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: _____

Plan/Referrals (dental, vision, hearing, dietary, etc):_____

Recommended Return Date:

Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations. Yes ☐ No ☐
Parent/Caregiver and/or Patient Signature:_____
Date:_____

Screening Providers Signature: _____

(Licensed Physician, ARNP, PA, or Registered Nurse credentialed to perform KAN Be Healthy screens)

form revised 12/6/07

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 No	Yes No	Yes No	Yes No	Yes No	Yes No
2) **Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
3) **Have a family member with an elevated blood lead level?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes 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 No	Yes No	Yes No	Yes No	Yes No	Yes No
5) **Live near a lead smelter, battery plant or other lead industry?** (Ammunition/explosives, auto repair/auto body, cable/wiring striping, 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 No	Yes No	Yes No	Yes No	Yes No	Yes No
6) **Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?**	Yes No	Yes No	Yes No	Yes No	Yes No	Yes 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?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Interviewing Staff Initials						

Staff Signature:

Patient Name: _____ I.D. Number: _____