

Revisions to Well Care (Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)) Exam Forms and Anticipatory Guidance Forms and Tables

- Forms are now one per visit to allow for more room for comments and extensive anticipatory guidance
- There are different forms for 13-14, 15-17 and 18-20 to allow anticipatory guidance to vary by age.
- A behavior health screen has been added for ages 9 and up.
 - Anticipatory Guidance tables that previously covered ages 7-13 and 14-20 now vary more by age.
- Anticipatory Guidance has additional topics added such as limits on TV/computer time, gangs, suicide/depression.

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code -circle one 99385-New, 99395-Estab
Accompanied by:		Allergies: NKA <input type="checkbox"/>		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Chart Exam-age 18 OD _____ OS _____ OU _____ Corrected / uncorrected	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:	LABS ORDERED:		
Skin/Hair/Nails			Tuberculin Test _____		
Ear/Hearing			(perform if at risk)		
Eyes/Vision			Hgb/Hct _____		
Mouth/Throat/Teeth			Urinalysis _____		
Nose/Head/Neck			Lipid profile (perform if at risk) _____		
Lungs			Other Tests: _____		
Heart					
Abdomen			Behavioral Screen (or substitute GAPS or other tool):		
Genitourinary/Breast			<input type="checkbox"/> Home Environment		
Pelvic Exam/STD Screening			<input type="checkbox"/> Education and Work Goals/Future Plans (risk)		
Extremities			<input type="checkbox"/> Drugs/Alcohol		
Back/Hips			<input type="checkbox"/> Depression/Suicide		
Neurological			<input type="checkbox"/> Sexual Activity		
ASSESSMENT & PLAN: (Confidential Documentation attached <input type="checkbox"/>)					
IMMUNIZATIONS					
Given Today:	Hep B _____	Td _____	MMR _____		
Varicella _____	Hep A _____	Influenza _____	Other _____		
ANTICIPATORY GUIDANCE PROVIDED					
<input type="checkbox"/> Good nutrition/Exercise	<input type="checkbox"/> Sports/Injury prevention	<input type="checkbox"/> Breast/Testicular self exam	<input type="checkbox"/> Social Interaction		
<input type="checkbox"/> Dental/Flossing/Self care	<input type="checkbox"/> Violence prevention/Gun safety	<input type="checkbox"/> Educational goals/Activities	<input type="checkbox"/> Family Functioning		
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Limit TV/Internet Use	<input type="checkbox"/> Self Control		
<input type="checkbox"/> Seat Belt/Driving safety	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Tobacco/Alcohol/Drugs/ Inhalants	<input type="checkbox"/> Depression/anxiety		
<input type="checkbox"/> Sport bike/Helmet use	<input type="checkbox"/> Sex Education/Counseling	<input type="checkbox"/> Peer refusal skills	<input type="checkbox"/> Transition to Internist/ Family Practice/GP		
REFERRALS: <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Nutritional <input type="checkbox"/> OB/GYN <input type="checkbox"/> Specialty: <input type="checkbox"/> WIC					
					Date Consult Report Received:
See Additional/Supervisory Note?					
Clinician Name (print)			Clinician Signature		Yes _____ No _____