

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>–circle one</i> 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	Temp: _____
Parental Comments/Concerns:	OD _____	Pulse: _____
	OS _____	Resp: _____
	OU _____	BP _____
	Corrected / uncorrected	

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 <input type="checkbox"/> Activities (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)

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: Behavioral Dental Nutritional OB/GYN Specialty: _____ WIC

Date Consult Report Received: _____

See Additional/Supervisory Note?

Clinician Name (print)	Clinician Signature	Yes	No
------------------------	---------------------	-----	----

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>–circle one</i> 99384-New, 99394-Estab
Accompanied by:		Allergies:NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Chart Exam-age 15	Temp: _____
Parental Comments/Concerns:				OD _____	Pulse: _____
				OS _____	Resp: _____
				OU _____	BP
				Corrected / uncorrected	
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 (if appropriate)				<input type="checkbox"/> Education and Work Goals/ Future Plans	
Extremities				<input type="checkbox"/> Activities (risk level)	
Back/Hips				<input type="checkbox"/> Drugs/Alcohol	
Neurological				<input type="checkbox"/> Depression/Suicide	
<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"/> Family Functioning		
<input type="checkbox"/> Dental/Flossing/Self care	<input type="checkbox"/> Violence prev./Gun safety	<input type="checkbox"/> Educational goals/activities	<input type="checkbox"/> Self Control		
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Limit TV/Internet Use	<input type="checkbox"/> Depression/Anxiety		
<input type="checkbox"/> Seat Belt/Driving safety	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Tobacco/Alcohol/Drugs/Inhalants	<input type="checkbox"/> Conflict resolution skills		
<input type="checkbox"/> Sport bike/Helmet use	<input type="checkbox"/> Sex Education/ Counseling	<input type="checkbox"/> Peer refusal skills/Gangs	<input type="checkbox"/> Transition Planning (age 16 on)		
		<input type="checkbox"/> Social Interaction	<input type="checkbox"/> Next appointment		
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 _____		

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>—circle one</i> 99384-New, 99394-Estab
Accompanied by:		Allergies: NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Exam (if needed)	Temp: _____
Parental Comments/Concerns:				OD _____	Pulse: _____
				OS _____	Resp: _____
				OU _____	BP _____
				Corrected / uncorrected	
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				Tuberculin Test _____	
Ear/Hearing				(perform if at risk)	
Eyes/Vision				Hgb/Hct _____	
Mouth/Throat/Teeth				Urinalysis _____	
Nose/Head/Neck				Lipid profile _____	
Lungs				(perform if at risk)	
Heart				Other Tests: _____	
Abdomen				Behavioral Screen (or substitute GAPS or other tool):	
Genitourinary/Breast				<input type="checkbox"/> Home Environment	
Pelvic Exam/STD Screening (if appropriate)				<input type="checkbox"/> Educational Goals	
Extremities				<input type="checkbox"/> Activities (risk level)	
Back/Hips				<input type="checkbox"/> Drugs/Alcohol	
Neurological				<input type="checkbox"/> Depression/Suicide	
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"/> Sex Education/Counseling	
<input type="checkbox"/> Dental/Flossing/Self care		<input type="checkbox"/> Violence prevention/Gun safety		<input type="checkbox"/> Educational goals/activities	
<input type="checkbox"/> Drowning/Sun Safety		<input type="checkbox"/> Parenting advice		<input type="checkbox"/> Limit TV/Internet Use	
<input type="checkbox"/> Seat Belt/Driving safety		<input type="checkbox"/> "Safe at home?"		<input type="checkbox"/> Tobacco/alcohol/drugs/inhalants	
<input type="checkbox"/> Sport bike/Helmet use				<input type="checkbox"/> Peer refusal skills/Gangs	
				<input type="checkbox"/> Social Interaction	
				<input type="checkbox"/> Family Functioning	
				<input type="checkbox"/> Self Control	
				<input type="checkbox"/> Conflict resolution skills	
				<input type="checkbox"/> Depression/anxiety	
				<input type="checkbox"/> Next appointment	
REFERRALS: <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Nutritional <input type="checkbox"/> OB/GYN <input type="checkbox"/> Specialty:					
				<i>Date Consult Report Received:</i>	
See Additional/Supervisory Note?					
Clinician Name (print)			Clinician Signature		
			Yes _____ No _____		

11, 12 Year Old

Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>–circle one</i> 99384-New, 99394-Estab age 12 99383-New, 99393-Estab age 11
Accompanied by:		Allergies:NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Exam at Age 12 OD _____ OS _____ OU _____ Corrected / uncorrected _____	
Parental Comments/Concerns:				Temp: _____ Pulse: _____ Resp: _____ BP _____ Fluoride checked? _____ (If well water)	
Dental Screen: Date of last exam: _____		Next appt: _____		Routine _____ Urgent _____ Parent advised _____ Adequate _____ Inadequate _____ Supplements: _____	
Nutritional Screen:				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			Tuberculin Test _____		
Ear/Hearing			(perform if at risk)		
Eyes/Vision			Hgb/Hct _____		
Mouth/Throat/Teeth			Urinalysis _____		
Nose/Head/Neck			Lipid profile _____		
Lungs			(perform if at risk)		
Heart			Other Tests: _____		
Abdomen			Behavioral Screen (or substitute GAPS or other tool):		
Genitourinary/Breast			<input type="checkbox"/> Home Environment		
Pelvic Exam/STD Screening (if appropriate)			<input type="checkbox"/> Activities (risk level)		
Extremities			<input type="checkbox"/> Educational Goals		
Back/Hips			<input type="checkbox"/> Depression/Suicide		
Neurological			<input type="checkbox"/> Sexual Activity		
			<input type="checkbox"/> Drugs/Alcohol		
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"/> Educational goals/Activities	<input type="checkbox"/> Self Control		
<input type="checkbox"/> Dental/Flossing/Self care	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Limit TV/Internet Use	<input type="checkbox"/> Depression/Anxiety		
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> "Violence prevention/Gun safety"	<input type="checkbox"/> Tobacco/alcohol/drugs/inhalants	<input type="checkbox"/> Conflict resolution skills		
<input type="checkbox"/> Seat Belt/Auto safety	<input type="checkbox"/> Safe at home?"	<input type="checkbox"/> Peer refusal skills/Gangs	<input type="checkbox"/> Parenting advice)		
<input type="checkbox"/> Sport bike/Helmet use	<input type="checkbox"/> Sex Education/ Counseling	<input type="checkbox"/> Social Interaction	<input type="checkbox"/> Next appointment		
		<input type="checkbox"/> Family Involvement			
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"/> Other					
				Date Consult Report Received: _____	
See Additional/Supervisory Note?					
Clinician Name (print)		Clinician Signature		Yes _____ No _____	

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>—circle one</i> 99383-New 99393-Established
Accompanied by:		Allergies: NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Exam	Temp: _____
Parental Comments/Concerns:				OD _____	Pulse: _____
				OS _____	Resp: _____
				OU _____	BP _____
				Corrected / uncorrected	Fluoride checked?
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? 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 _____
Lungs					(perform if at risk)
Heart					Other Tests: _____
Abdomen					Behavioral Screen
Genitourinary/Breast					(or substitute GAPS or other tool):
Extremities					<input type="checkbox"/> Home Environment
Back/Hips					<input type="checkbox"/> Educational <input type="checkbox"/> Activities
Neurological					Goals (risk level)
					<input type="checkbox"/> Drugs/Alcohol/Inhalants
					<input type="checkbox"/> Depression/Anxiety
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"/> Sex Education	<input type="checkbox"/> Family Functioning		
<input type="checkbox"/> Dental/Flossing/Self care	<input type="checkbox"/> Violence prevention/Gun safety	<input type="checkbox"/> Educational goals/Activities	<input type="checkbox"/> Self Control		
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Limit TV/Video/Internet Use	<input type="checkbox"/> Depression/Anxiety		
<input type="checkbox"/> Seat Belt/Auto safely	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Tobacco/alcohol/drugs/inhalants	<input type="checkbox"/> Conflict resolution skills		
<input type="checkbox"/> Sport bike/helmet use	<input type="checkbox"/> Afterschool/Child Care Issues	<input type="checkbox"/> Peer refusal skills/Gangs	<input type="checkbox"/> Parenting advice		
		<input type="checkbox"/> Social Interaction	<input type="checkbox"/> Next appointment		
REFERRALS: <input type="checkbox"/> Behavioral <input type="checkbox"/> Dental <input type="checkbox"/> Nutritional <input type="checkbox"/> OB/GYN <input type="checkbox"/> Specialty:					
					Date Consult Report Received:
See Additional/Supervisory Note?					
Clinician Name (print)		Clinician Signature		Yes	No

7-8 Year Old

Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code - <i>circle one</i> 99383-New, 99393-Established
Accompanied by:		Allergies: NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Exam (if needed-@) OD _____ OS _____ OU _____ Corrected / uncorrected _____	
Parental Comments/Concerns:				Temp: _____ Pulse: _____ Resp: _____ BP _____ Fluoride checked? _____	
Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____ (If well water)					
Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____ Healthy Food Choices <u>Yes/No</u>					
Hearing Screen: Within normal limits? (@ - if not done at school) Yes _____ No _____ Physical Activity: _____					
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 _____		
Lungs			(perform if at risk)		
Heart			Other Tests: _____		
Abdomen			Behavioral/Developmental Screen		
Genitourinary			<input type="checkbox"/> Home Environment <input type="checkbox"/> Activities (risk level)		
Extremities			<input type="checkbox"/> General Screen (e.g. PEDS or other)		
Back/Hips			<input type="checkbox"/> School Attendance <input type="checkbox"/> School Performance		
Neurological			<input type="checkbox"/> Social Interactions		
ASSESSMENT & PLAN: (Confidential Documentation attached <input type="checkbox"/>)					
IMMUNIZATIONS					
Given Today:		Hep B _____	PCV _____	Varicella _____	
Hep A _____	Influenza _____	Other _____			
ANTICIPATORY GUIDANCE PROVIDED					
<input type="checkbox"/> Good nutrition/Exercise <input type="checkbox"/> Dental/ Flossing/Self care <input type="checkbox"/> Drowning/Sun Safety <input type="checkbox"/> Seat Belt/Auto safety <input type="checkbox"/> Sport bike/Helmet use		<input type="checkbox"/> Sports/Injury prevention <input type="checkbox"/> Violence prevention/Gun safety <input type="checkbox"/> Passive Smoke <input type="checkbox"/> "Safe at home?" <input type="checkbox"/> Afterschool/Child Care Issues		<input type="checkbox"/> Sex Education <input type="checkbox"/> Limit TV/Video/Internet Use <input type="checkbox"/> Tobacco/Alcohol/Drugs/ Inhalants <input type="checkbox"/> Social Interaction <input type="checkbox"/> Family Functioning	
				<input type="checkbox"/> Self Control <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Conflict resolution skills <input type="checkbox"/> Parenting advice <input type="checkbox"/> Next appointment	
REFERRALS: <input type="checkbox"/> Behavioral/Developmental <input type="checkbox"/> Dental <input type="checkbox"/> Nutritional <input type="checkbox"/> Specialty: <input type="checkbox"/> Other					
				Date Consult Report Received: _____	
See Additional/Supervisory Note?					
Clinician Name (print)		Clinician Signature		Yes	No

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code - <i>circle one</i> 99383-New, 99393-Established
------	------------	-------------	---------------	-----	--

Accompanied by:	Allergies: NKA <input type="checkbox"/> _____	Current Medication(s)
-----------------	---	-----------------------

--	--	--	--	--	--

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
---------	-------------	---------	-------------	------	-------------

HISTORY:	Vision Exam (if needed @)	Temp: _____
	OD _____	Pulse: _____
	OS _____	Resp: _____
	OU _____	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

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test _____
Ear/Hearing			(perform if at risk)
Eyes/Vision			Verbal Lead Risk Assessment _____
Mouth/Throat/Teeth			Blood lead test (perform once, at age up to 72 months)
Nose/Head/Neck			Additional Labs Ordered:
Lungs			Hgb/Hct _____
Heart			Urinalysis _____
Abdomen			Other:
Genitourinary			<input type="checkbox"/> Behavioral/Developmental Screen (or substitute GAPS or other tool):
Extremities			<input type="checkbox"/> Home Environment <input type="checkbox"/> Activities (risk level)
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other)
Neurological			<input type="checkbox"/> School Attendance <input type="checkbox"/> School Performance
			<input type="checkbox"/> Social Interactions

ASSESSMENT & PLAN: (Confidential Documentation attached)

IMMUNIZATIONS Given Today: Hep B _____ DTaP _____ IPV _____
 MMR _____ Varicella _____ Hep A _____ Influenza _____ Other _____

ANTICIPATORY GUIDANCE PROVIDED

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

REFERRALS: Behavioral/Developmental Dental Nutritional Specialty: _____ Other _____

Date Consult Report Received: _____

See Additional/Supervisory Note?

Clinician Name (print)	Clinician Signature	Yes	No
------------------------	---------------------	-----	----

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>–circle one</i> 99383-New, 99393-Established
------	------------	-------------	---------------	-----	---

Accompanied by:	Allergies: NKA <input type="checkbox"/> _____	Current Medication(s)
-----------------	---	-----------------------

--	--	--	--	--	--

Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
---------	-------------	---------	-------------	------	-------------

HISTORY:	Vision Exam OD _____ OS _____ OU _____ Corrected / uncorrected _____	Temp: _____ Pulse: _____ Resp: _____ BP _____ 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) 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 _____
Ear/Hearing			(perform if at risk)
Eyes/Vision			Verbal Lead Risk Assessment _____
Mouth/Throat/Teeth			Blood lead test (if not done since age 1) _____
Nose/Head/Neck			Additional Labs Ordered:
Lungs			Hgb/Hct (HRisk/WIC) _____
Heart			Urinalysis _____
Abdomen			Other: _____
Genitourinary			Behavioral /Developmental Screen
Extremities			<input type="checkbox"/> Home Environment
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other tool)
Neurological			<input type="checkbox"/> Activities (risk level)

ASSESSMENT & PLAN: (Confidential Documentation attached)

IMMUNIZATIONS Given Today: PCV _____ Hep B _____ DTaP _____ IPV _____

MMR _____ Varicella _____ Hep A _____ Influenza _____ Other _____

ANTICIPATORY GUIDANCE PROVIDED

<input type="checkbox"/> Good nutrition/Exercise	<input type="checkbox"/> Sports/injury prevention	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Social Interaction
<input type="checkbox"/> Dental care	<input type="checkbox"/> Violence prevention/Gun safety	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Family Dynamics
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> Fire Safety	<input type="checkbox"/> Toileting Habits	<input type="checkbox"/> Self Control
<input type="checkbox"/> Car Seat /Auto safety	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Reading to child/ School readiness	<input type="checkbox"/> Parenting advice
<input type="checkbox"/> Sport bike/Helmet use	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Limit TV/Video/Internet Use	<input type="checkbox"/> Next appointment

REFERRALS: WIC Behavioral Dental Nutritional Speech Specialty:

	<i>Date Consult Report Received:</i>
	See Additional/Supervisory Note?
	Yes _____ No _____

Clinician Name (print)	Clinician Signature	Yes	No
------------------------	---------------------	-----	----

4 Year Old

Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>-circle one</i> 99382-New, 99392-Estab
Accompanied by:		Allergies: NKA <input type="checkbox"/> _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:
HISTORY:				Vision Exam	
				OD _____	Temp: _____
Parental Comments/Concerns:				OS _____	Pulse: _____
				OU _____	Resp: _____
				Corrected / uncorrected	Fluoride checked?
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 _____		
Ear/Hearing			(perform if at risk)		
Eyes/Vision			Verbal Lead Risk Assessment _____		
Mouth/Throat/Teeth			Blood lead test (if not done since age 1) _____		
Nose/Head/Neck			Additional Labs Ordered:		
Lungs			Hgb/Hct (HRisk/WIC) _____		
Heart			Urinalysis _____		
Abdomen			Other: _____		
Genitourinary			Behavioral /Developmental Screen		
Extremities			<input type="checkbox"/> Home Environment		
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other tool)		
Neurological			<input type="checkbox"/> Activities (risk level)		
ASSESSMENT & PLAN: (Confidential Documentation attached <input type="checkbox"/>)					
IMMUNIZATIONS Given Today: Hep B _____ Td _____ MMR _____ IPV _____					
DTaP _____ Influenza _____ Varicella _____ Hep A _____ Other _____					
ANTICIPATORY GUIDANCE PROVIDED					
<input type="checkbox"/> Good nutrition/Exercise	<input type="checkbox"/> Sport bike/Helmet use	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Limit TV/Internet Use	<input type="checkbox"/> Social Interaction
<input type="checkbox"/> Dental care	<input type="checkbox"/> Sports/Injury prevention	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Family functioning	<input type="checkbox"/> Self Control
<input type="checkbox"/> Drowning/Sun Safety	<input type="checkbox"/> Violence prevention/Gun safety	<input type="checkbox"/> Toileting Habits	<input type="checkbox"/> Reading to child/ Pre-school	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Next appointment
<input type="checkbox"/> Car Seat/Auto safety	<input type="checkbox"/> Fire Safety	<input type="checkbox"/> Passive Smoke			
REFERRALS: <input type="checkbox"/> WIC <input type="checkbox"/> Behavioral/ Developmental <input type="checkbox"/> Dental <input type="checkbox"/> Nutritional <input type="checkbox"/> Speech					
<input type="checkbox"/> Specialty <input type="checkbox"/> Other					
Date Consult Report Received: _____					
See Additional/Supervisory Note?					
Yes _____ No _____					
Clinician Name (print)			Clinician Signature		