NEVADA HEALTHY KIDS (EPSDT)

Initial New Patient Screening Form (CPT 99381-99385)

Name **Date** **DOB** **Age** **Sex**

Medicaid# **Parent/Guardian Name** **Provider NPI**

Patient's Medical History

Birth Weight **Birth Length** **Serious Injury/Illness** **Surgeries**

Menarch/Sexual History (if applicable)

Family Medical History (Check disease & indicate family member with the problem: **P**-parent **G**-grandparent **B**-Brother, **S**-Sister)

Asthma/Allergies ☐	**Heart Attack/Stroke** ☐	**Scoliosis/Arthritis** ☐	**Retardation** ☐
Birth Defects ☐	**High Blood Pressure** ☐	**Substance Abuse** ☐	**Mental Illness** ☐
Blood/Sickle Cell ☐	**Kidney/Liver Disease** ☐	**Urinary Problems** ☐	**Disabilities** ☐
Cancer ☐	**Lung Disease** ☐	**Ulcers/Stomach Upset** ☐	**Other**
Diabetes ☐	**Obesity** ☐	**Bowel Problems** ☐	**Behavioral/Emotional History**

Growth/Vital Signs

Ht **(_____%)** **Temp** **Pulse** **Resp** **B/P** **Allergies**

Wt **(_____%)** **Current Medications** **Nutrition**

HC or BMI **(_____%)** **Present Concerns**

Physical Exam-unclothed (**N**- Normal **A**- Abnormal **NE**- No exam)

N	A	NE		N	A	NE		N	A	NE	
☐	☐	☐	**Appearance**	☐	☐	☐	**Nose**	☐	☐	☐	**Abdomen**
☐	☐	☐	**Head/Face**	☐	☐	☐	**Mouth/Teeth**	☐	☐	☐	**Genitalia**
☐	☐	☐	**Hair/Scalp**	☐	☐	☐	**Neck**	☐	☐	☐	**Musculoskeletal**
☐	☐	☐	**Eyes/Vision Screen**	☐	☐	☐	**Heart/Lungs**	☐	☐	☐	**Extremities**
☐	☐	☐	**Ears/Hearing Screen**	☐	☐	☐	**Skin/Nodes**	☐	☐	☐	**Neuro**

Describe any abnormalities

Developmental/Emotional Behavior

Age/Culturally appropriate (i.e. through parental interview, observation or screening tool): ☐ **Yes** ☐ **No**

Name of screening tool, if used: **Referral:**

Anticipatory Guidance/Nutrition/Safety (Check each one that is discussed with patient/caregiver.)

☐ **Nutrition**	☐ **Adequate Sleep**	☐ **Limit TV/Computer Time**	☐ **Maternal/Caregiver Depression**
☐ **Vitamins**	☐ **Active Play**	☐ **Social/School Adjustment**	
☐ **Brush Teeth/Visit Dentist**	☐ **No Smoking in House/Car**	☐ **Privacy/Hygiene**	
☐ **Family Relationships**	☐ **Car Seat/Safety Belt**	☐ **Puberty/Sex**	

Impression

Well Child ☐ **Yes** ☐ **No Dx:** **Normal Growth/Development** ☐ **Yes** ☐ **No Dx:** **Next screening due at age**

Treatment Plan/Referral

☐ **Fluoride Varnish Application** ☐ **Refer to dentist** ☐ **Refer to Specialist** **Type of Specialist**

Immunizations Given ☐ **Up-to-date**

☐ **DTaP** (DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td)	☐ **MMR**(MMR, MMRV)
☐ **Hib** (Hib, Hib-HepB, DTaP-Hib)	☐ **Meningococcal** (MCV4, MPSV4)
☐ **Hep A**	☐ **Pneumococcal** (PCV, conjugate, PPV, polysaccharide)
☐ **Hep B** (HepB, Hib-HepB, DTap-HepB-IPV)	☐ **Polio** (IPV, DTaP-HepB-IPV)
☐ **HPV**	☐ **Rotavirus**
☐ **Influenza** (TIV, LAIV)	☐ **Varicella** (Var, MMRV)

Laboratory Ordered ☐ **Up-to-date**

☐ **Hgb/Hct** ☐ **Lead** ☐ **PKU** ☐ **Sickle Cell** ☐ **TB Test** ☐ **U/A** ☐ **Other**

Provider Signature: _____ **Date:** _____