

## Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

Please COMPLETELY fill in this form by supplying the requested information and filling in the appropriate

PATIENT INFORMATION																																			
Screen Date (MMDDYY)					Indicate the EPSDT periodic screening age being reported															Sex															
					14 d	30 d	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y	M	F								
					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Name (Last, First, Middle Initial)										Medicaid/QUEST ID					Birthdate (MMDDYY)																				
										0 0																									
MEASUREMENTS																																			
For infants, head circumference and weight for length should be assessed and documented in the Medical record.																																			
Blood Pressure					Height (In)					Weight (Lbs)					BMI #			BMI %			BMI Reference – For Information Only														
																					Normal < 85%		Overweight 85%-94%		Obese ≥95%										
/																																			
IMMUNIZATIONS GIVEN TODAY AND STATUS																																			
HepB	<input type="radio"/>	PCV	<input type="radio"/>	MMR	<input type="radio"/>	Tdap	<input type="radio"/>	Immunization(s) Not Given																											
DTaP	<input type="radio"/>	Rotav	<input type="radio"/>	Varicella	<input type="radio"/>	MCV4/MPSV4	<input type="radio"/>	Immunizations up to date																	<input type="radio"/>										
IPV	<input type="radio"/>	Influenza	<input type="radio"/>	HepA	<input type="radio"/>	HPV	<input type="radio"/>	Catch Up Scheduled																	<input type="radio"/>										
Hib	<input type="radio"/>	Other (List)					<input type="radio"/>	Refused (List)																	<input type="radio"/>										
Comments:										Contraindicated (List)										<input type="radio"/>															
SCREENING DONE TODAY																																			
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y															<input type="radio"/>	<input type="radio"/>	Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)					<input type="radio"/>													
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y															<input type="radio"/>	<input type="radio"/>	Hgb/Hct 9m – 12m, Females-12y – 14y					<input type="radio"/>													
Developmental Screening *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)					PEDS: ≥ 2 predictive concerns = Abnormal					<input type="radio"/>	<input type="radio"/>	Comments for screenings not done:					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																
					ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal					<input type="radio"/>	<input type="radio"/>																								
					Other (list)																														
Autism Screening *(see back) 18m, 24m Fail = Abnormal					CHAT					<input type="radio"/>	<input type="radio"/>	Has the child seen a dentist within the past year?					<input type="radio"/>	<input type="radio"/>																	
					M-CHAT					<input type="radio"/>	<input type="radio"/>																								
					Other (list)																														
As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents- alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening.																																			
REFERRALS MADE TODAY																																			
By leaving this section blank, I am confirming that there are no referral needs.																																			
Already referred or receiving state or specialty services.					<input type="radio"/>	H-KISS					<input type="radio"/>	PHN					<input type="radio"/>	CAMHD					<input type="radio"/>	WIC					<input type="radio"/>						
Patient/parent refused.					<input type="radio"/>	PT/OT/Speech/Audiology					<input type="radio"/>	DOE					<input type="radio"/>	DDD					<input type="radio"/>	Child Welfare					<input type="radio"/>	Dentistry					<input type="radio"/>
Behavioral Health/Substance Abuse (List name & specialty)										<input type="radio"/>	Nutrition/Exercise (List name & specialty)															<input type="radio"/>									
Medical/Surgical/Developmental (List name & specialty)										<input type="radio"/>	Other(s) (List name & specialty)															<input type="radio"/>									
CARE COORDINATION ASSISTANCE NEEDED																																			
Please call patient's Health Plan for Care Coordination assistance if needed.																																			
No Care Coordination Needed					<input type="radio"/>	Managing medical condition and/or medications					<input type="radio"/>	Obtaining foreign/sign language translation					<input type="radio"/>	Obtaining dental care (If yes, call CCMC)					<input type="radio"/>	Scheduling/Keeping appointments					<input type="radio"/>						
Arranging transportation					<input type="radio"/>	Coordinating multiple appointments					<input type="radio"/>	Family needs assistance in following the POC					<input type="radio"/>	Obtaining specialty services					<input type="radio"/>	Other					<input type="radio"/>						
If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.										List additional information or other assistance needed:																									
Phone Numbers					Aloha Care 808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)					Kaiser QUEST 808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)					CCMC Dental Resource 808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)																				
					HMSA QUEST 808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)					Ohana Health Plan 1-888-846-4262					UnitedHealthcare 1-888-980-8728																				
PROVIDER STATEMENT: A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record.																																			
Provider Name (Print)										Signature										NPI #															
For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).																																			