

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH UP & FOLLOW-UP FORM

Please fill in this form by supplying the requested information and filling in the appropriate for the areas covered by today's visit

The DHS 8016 form should be used to document the completion of any screening(s) and/or immunization(s) that were attempted and not done during a comprehensive EPSDT Screening visit (8015 document). In addition, the 8016 must be used to document any immunization or screening not captured on the 8015, or not associated with a comprehensive EPSDT screening visit.

PATIENT INFORMATION

Screen Date (MMDDYY)						Name (Last, First, Middle Initial)											
Medicaid/QUEST ID										Birthdate (MMDDYY)						Sex	
0	0															M <input type="radio"/>	F <input type="radio"/>

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	<input type="radio"/>	PCV	<input type="radio"/>	MMR	<input type="radio"/>	Tdap	<input type="radio"/>	DTaP	<input type="radio"/>	Rotav	<input type="radio"/>	Varicella	<input type="radio"/>	MCV4/MPSV4	<input type="radio"/>
IPV	<input type="radio"/>	Influenza	<input type="radio"/>	HepA	<input type="radio"/>	HPV	<input type="radio"/>	Hib	<input type="radio"/>	Other (List)					<input type="radio"/>

Comments:

SCREENING DONE TODAY

	Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y	<input type="radio"/>	<input type="radio"/>
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y	<input type="radio"/>	<input type="radio"/>
Dev: PEDS/ASQ *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal	
	ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal	
	Other (list)	
Autism: CHAT, M-CHAT *(see back) 18m, 24m	Fail = Abnormal	
	Other (list)	

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"/>
Behavioral Health/Substance Abuse (List)	<input type="radio"/>	Nutrition/Exercise (List)						<input type="radio"/>	
Medical/Surgical/Developmental (List)	<input type="radio"/>	Other(s) (List)						<input type="radio"/>	

CARE COORDINATION ASSISTANCE NEEDED Please call patient's Health Plan for Care Coordination assistance if needed.

Phone Numbers	AlohaCare	Kaiser QUEST	CCMC Dental Resource
	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	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

Comments:

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).