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

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
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Sex: M ○ F ○

Name (Last, First, Middle Initial)

Medicaid/QUEST ID: 0 0

Birthdate (MMDDYY)

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	○	PCV	○	MMR	○	Tdap	○
DTaP	○	Rotav	○	Varicella	○	MCV4/MPSV4	○
IPV	○	Influenza	○	HepA	○	HPV	○
Hib	○	Other (List)					○

Comments:

Immunization(s) Not Given	
Immunizations up to date	○
Catch Up Scheduled	○
Refused (List)	○
Contraindicated (List)	○

SCREENING DONE TODAY

Screening		Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y		○	○
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y		○	○
Developmental Screening *(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 Screening *(see back) 18m, 24m Fail = Abnormal	CHAT M-CHAT Other (list)	○	○

	Done
Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)	○
Hgb/Hct 9m – 12m, Females-12y – 14y	○

Comments for screenings not done:

	Y	N
Has the child seen a dentist within the past year?	○	○

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.	○	H-KISS	○	PHN	○	CAMHD	○	WIC	○
Patient/parent refused.	○	PT/OT/Speech/Audiology	○	DOE ○ DDD	○	Child Welfare	○	Dentistry	○

Behavioral Health/Substance Abuse (List name & specialty)	○	Nutrition/Exercise (List name & specialty)	○
Medical/Surgical/Developmental (List name & specialty)	○	Other(s) (List name & specialty)	○

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

No Care Coordination Needed	○	Managing medical condition and/or medications	○	Obtaining foreign/sign language translation	○	Obtaining dental care (If yes, call CCMC)	○	Scheduling/Keeping appointments	○
Arranging transportation	○	Coordinating multiple appointments	○	Family needs assistance in following the POC	○	Obtaining specialty services	○	Other	○

If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.

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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).