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

PATIENT INFORMATION

Health Plan: ○ AC ○ HQ ○ KQ ○ SU ○ MA ○ OT

Island of Residence: ○ HI ○ KA ○ LA ○ MA ○ MO ○ OA

Indicate the EPSDT periodic screening age being reported: ○ 14d ○ 30d ○ 2m ○ 4m ○ 6m ○ 9m ○ 12m ○ 15m ○ 18m ○ 2y ○ 3y ○ 4y ○ 5y ○ 6y ○ 8y ○ 10y ○ 12y ○ 14y ○ 16y ○ 18y ○ 20y

Type: ○ NEW ○ EST

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Medicaid/QUEST ID	Birthdate (MMDDYY)	M	F
		0 0 0		○	○

HISTORY FOR INFANTS (FIRST YEAR OF LIFE)

APGAR	BIRTH WEIGHT - g	Mother's Medicaid/QUEST ID#	#

List any birth/newborn complications, including abnormal NB Screens, significant illnesses, injuries, surgery, and hospitalizations. (*APGAR, Birth Weight are optional after 1 year of age*)

HISTORY FOR CHILDREN OLDER THAN 1 YEAR OF AGE: List below any significant illnesses, injuries, surgery, hospitalization, or applicable family history

MEASUREMENTS

Temperature-C or F	Blood Pressure	Height-cm	Weight-kg	BMI	Head Circ.-cm	Allergies ○	Medications ○
.	/		.	.	.	List:	

PHYSICAL EXAMINATION normal except as noted

SURVEILLANCE normal except as noted

Vision/Hearing/Dental/Oral/ Development and Behavior, Lead & TB Assessment, Health Education, Counseling & Age Appropriate Anticipatory Guidance

List all abnormal findings and/or concerns noted in Measurements, the Physical Exam, Surveillance and/or Screening (Also list other screening tools used). *Use this space for additional comments on history*

SCREENING done today	Y	N
Snellen/Allen 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y 16y, 18y, 20y	○	○
Audiogram (20-25 db screen) 4y-6y	○	○
Blood Lead Level 9m – 12m, 2y	○	○
Hgb/Hct 9m – 12m, Females-12y – 14y	○	○
PPD 12m, 2-6y, 12-14 y	○	○
Dev: PEDS/ASQ 9m, 12m, 18m, 2y, 3y, 4y, 5y	○	○
Other Dev/Beh – List	○	○

DIAGNOSIS/STATUS

○ Well child ○ Acute Illness ○ CSHCN

List ICD-9 Codes of CSHCN: . . .

List Acute illness(es):

REFERRALS MADE TODAY ○ Y – indicate below ○ N

○ H-KISS	○ DDD	○ Cardiology	○ Neurology	○ Ophthalmology
○ PHN	○ Child Welfare	○ Psychiatry or Psychology	○ Otolaryngology	○ Nephrology
○ CAMHD	○ DOE	○ Orthopedics	○ Gastroenterology	○ Urology
○ Developmental/Behavioral		○ Dentistry	○ Other(s)--list	

Print names of specialists to whom referrals were made today

CARE COORDINATION ASSISTANCE NEEDED ○ Y – indicate below ○ N

List additional information or other assistance needed

○ Arranging transportation	○ Managing medical condition and/or medications
○ Scheduling/Keeping appointments	○ Coordinating multiple appointments
○ Obtaining dental care	○ Obtaining specialty services
○ Obtaining foreign/sign language translation	○ Other
○ Written plan of care (POC) has been given to the family	○ Family needs assistance in following the POC

If assistance is needed, please provide parent's/ caregiver's telephone no. to facilitate coordination: -

IMMUNIZATIONS GIVEN TODAY AND STATUS ○ Y – indicate below ○ N

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

List Other(s) ○ Immunizations up to date ○ Catch up scheduled

PROVIDER INFORMATION: By signing below, I attest that the services indicated above were performed today by me or my staff under my supervision.

PCP Y / N	Provider Name (Print)	Signature	NPI #	Phone #
○ ○				-

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