



# KAN Be Healthy (EPSDT) Screening Form

I.D. Number: \_\_\_\_\_

Please note the Mandatory Blood Lead Questionnaire is a separate document. It is required at each screen 6 to 72 months

Name	Date of Birth	Age	Date of Screen
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## PHYSICAL GROWTH

T	Weight _____ (lbs/kg) _____ th%	Weight/Length _____ %	Head Circ (≤ 24 months) _____ cm/in
P	Length (Birth to 24 months) _____ cm/in	Standing Height (2 - 20 years) _____ cm/in	
R	BMI _____ th%		
BP	BMI ≥ 85%: recommend appropriate nutrition input and physical activity.		
Update Growth Chart (required at each screen)			Male <input type="checkbox"/> Female <input type="checkbox"/>

## BENEFICIARY & FAMILY HISTORY

Refer to completed history form in chart. Present Concern: \_\_\_\_\_

No changes in medical Hx unless indicated. \_\_\_\_\_

Previous Hx reviewed from \_\_\_\_\_ visit. \_\_\_\_\_

Patient currently in Foster care, no previous hx available. \_\_\_\_\_

Medications: \_\_\_\_\_ Serious Illness/Accidents:  No  Yes (date & type)

(including Hospital or ER visits) \_\_\_\_\_

Allergies (food & drug) \_\_\_\_\_

Birth History (Length, weight, complications, etc. - if known) \_\_\_\_\_ Operations:  No  Yes (date & type)

(Circle and indicate the relationship with disease / problem. P-Parent, G-Grandparent, B-Brother, S-Sister, Self)

Allergies (food & drug) _____	Drug or ETOH Abuse _____	Mental Illness _____
Asthma _____	Earaches _____	Obesity _____
Birth defects _____	Epilepsy/Seizures _____	Scoliosis/Arthritis _____
Blood Disorder/ Sickle Cell _____	Headache _____	Speech, Visual, Hearing _____
Cancer _____	High Blood Pressure _____	Ulcers/Colitis _____
Colds/sore throat _____	Kidney/Liver Disease _____	Urinary/Bowel _____
Diabetes _____	Lung Disease _____	Heart Disease/Stroke _____

## BODY SYSTEMS

SYSTEMS	WNL	ABN	Comments (Describe any Abnormal Findings)
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	
Head-Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes/Ears/Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Oral/Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	Lung sounds?
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	Murmur?
Abdomen/Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Tanner Score (as appropriate): Evaluate for excessive menstrual bleeding Enuresis
Trunk / Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	

**Vision Screen**

<b>Ages 0 to 3 yr</b> - Corneal Light Reflex Present: Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ages 3 yr thru 20</b> - Bruckner Exam: Pass <input type="checkbox"/> Refer <input type="checkbox"/> <b>All ages</b> - Outer Inspection: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Eye Tracking: Pass <input type="checkbox"/> Refer <input type="checkbox"/> PERRLA: Pass <input type="checkbox"/> Refer <input type="checkbox"/> Ocular Motility(strabismus/cross cover test):Pass <input type="checkbox"/> Refer <input type="checkbox"/>	<b>Ages 3 thru 20:</b> Distance Acuity - _____ Near Acuity - _____ Tool used: _____ Tool used: _____ Score: L _____ R _____ Both _____ Score: L _____ R _____ Both _____ Last exam: _____ Further comments (see below)
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**NUTRITION**

**PHYSICAL ACTIVITY**

<input type="checkbox"/> WIC participant <input type="checkbox"/> Referred to WIC <input type="checkbox"/> Breast Feeding <input type="checkbox"/> Formula Amount & how often: _____ Number of Servings per day Bread/Cereal _____ Dairy _____ Fat/Sweet/Sugar _____ Fruit _____ Meat/Bean/Egg _____ Vegetable _____ Fluid Intake: water _____ oz. Soda _____ Milk _____ oz. Juice _____	<input type="checkbox"/> Biking <input type="checkbox"/> Basketball <input type="checkbox"/> play outside <input type="checkbox"/> Skating <input type="checkbox"/> Walking <input type="checkbox"/> other sports How many hours screen time/Day? (i.e. TV, Games, PC) <input type="checkbox"/> 0-1 hr <input type="checkbox"/> 1-2hr <input type="checkbox"/> 3-5hrs <input type="checkbox"/> 5+hrs <b>KBH participant currently pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", then complete following : 1. Prenatal Record initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. On prenatal vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Referred for OB/GYN cares? <input type="checkbox"/> Yes <input type="checkbox"/> No Referred to: _____
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**LABORATORY**

**IMMUNIZATIONS**

Obtain CBC with automated differential in infants between 9-12 months. Obtain CBC with automated differential in males at age 15 and in females at menarche. Annual CBC's with diff are required depending on lifestyle/ health needs, please see Provider Manual. Was CBC obtained? Yes <input type="checkbox"/> No <input type="checkbox"/> Indicate further follow-up in Plan of Care.	Copy of record in chart Current <input type="checkbox"/> Behind <input type="checkbox"/> Unknown <input type="checkbox"/> Requested from Parent <input type="checkbox"/> Referred to VFC provider <input type="checkbox"/> Needs (circle): Rota HepB DTaP Flu Hib IPV MMR MCV4 MPSV4 PCV Varicella HepA HPV Other: _____
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**DEVELOPMENTAL / EMOTIONAL**

**DENTAL**

<i>Please refer to KMAP Provider Manual for AAP recommended Developmental Tools.</i> <b>Children &lt; 6 yrs.</b> A completed developmental screening tool to include the screener's interpretation and report regarding meeting developmental milestones. If further testing/intervention is required, please include in Plan of Care. <b>Children 6-21 yrs.</b> A completed developmental screening tool to include the screener's interpretation and report or document all developmental/emotional observations found below. Include further testing/intervention needs in Plan of Care. Developmental Tool used: _____ Sleep Habits _____ Tired / overactive? _____ Discipline: _____ Vocational concerns? _____ Peer Interaction: _____ Exercise _____ Grade Level _____ Average Marks _____ Special Education: _____ Special Needs: _____ Any emotional or behavioral problems? _____ Emotional Observations: _____	Sees Dentist? Yes <input type="checkbox"/> No <input type="checkbox"/> Last dental exam date: ____/____/____ # times brushes/day: _____ Dental Referral (annually at a minimum 1-20yr) Yes <input type="checkbox"/> No <input type="checkbox"/> ~ Fluoride Varnish? Yes <input type="checkbox"/> No <input type="checkbox"/>
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**HEARING SCREEN**

<b>HEALTH EDUCATION AND ANTICIPATORY GUIDANCE</b> <p align="center">Circle Those Reviewed/ Handouts Given</p> 1. Behavior/Discipline      5. Family Planning      9. Parenting      13. Self Breast Exam 2. Oral /Dental              6. Immunizations        10. Safety/Poisons    14. Sexuality 3. Development              7. Lifestyle                11. Substance Abuse   15. Exercise 4. Physical Activity         8. Nutrition                12. Self Testicular Exam 16. Weapon Safety 17. Other: _____	Maintain in record completed paper hearing screens & report or qualifying hearing screen procedure & report. Age birth to 4, perform Risk Indicators for Hearing Loss and Hearing Developmental Scales Pass <input type="checkbox"/> Refer <input type="checkbox"/> Hearing Health History >4: _____ Pass <input type="checkbox"/> Refer <input type="checkbox"/> Or Screen Procedure: _____
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**RESULTS/PLAN OF CARE**

<b>Screening Results:</b> _____ <b>Plan/Referrals (dental, vision, hearing, dietary, etc):</b> _____ _____ <b>Screening Providers Signature:</b> _____	<b>Recommended Return Date:</b> _____ <b>Parent/Caregiver and/or Patient informed of KBH Screen findings and verbalizes understanding of findings and recommendations.</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Parent/Caregiver and/or Patient Signature:</b> _____ <b>Date:</b> _____
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# Mandatory Blood Lead Screening Questionnaire

To be completed at each KBH Screen from 6 to 72 months

<b>Does your child:</b> (circle response received)	<b>DATE:</b> (MM/DD/YYYY)						
<b>1) Live in or visit a house or apartment built before 1960?</b> (This could include a day care center, preschool, the home of a baby-sitter or relative, etc.)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>2) Live in or regularly visit a house or apartment built before 1960 with previous, ongoing or planned renovation or remodeling?</b>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>3) Have a family member with an elevated blood lead level?</b>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>4) Interact with an adult whose job or hobby involves exposure to lead?</b> (Furniture refinishing, making stained glass, electronics, soldering, automotive repair, making fishing weights and lures, reloading shotgun shells and bullets, firing guns at a shooting range, doing home repairs and remodeling, painting/stripping paint, antique/imported toys, and/or making pottery).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>5) Live near a lead smelter, battery plant or other lead industry?</b> (Ammunition/explosives, auto repair/auto body, cable/wiring striping, splicing or production, ceramics, firing range, leaded glass factory, industrial machinery/equipment, jewelry manufacturer or repair, lead mine, paint/pigment manufacturer, plumbing, radiator repair, salvage metal or batteries, steel metalwork, or molten (foundry work)).	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>6) Use pottery, ceramic, or crystal wear for cooking, eating, or drinking?</b>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>One positive response to the above questions <u>requires</u> a blood lead level test. Please, remember blood lead level tests are required at 12 and 24 months, regardless of the score. Was blood drawn for a blood lead level test?</b>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
<b>Interviewing Staff Initials</b>							

**Staff Signature:**


**Patient Name:** \_\_\_\_\_ **I.D. Number:** \_\_\_\_\_



## Cuestionario Obligatorio para Examen de Plomo en la Sangre

**Debe ser completado en cada examen de KBH de 6 a 72 meses**

<b>Su hijo:</b> (circule la respuesta recibida)	<b>FECHA:</b> (MM/DD/YYYY)						
1) ¿A vivido en o visitado una casa o apartamento construido antes del 1960? (Esto puede incluir una guardería, preschool, la casa de su niñera o un pariente, etc.)	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
2) ¿A vivido en o visitado regularmente una casa o apartamento construido antes del 1960 que este, aya estado, o vaya estar bajo renovación o remodelación?	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
3) ¿Tiene un pariente con un alto nivel de plomo en la sangre?	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
4) ¿Tiene comunicación con un adulto que trabaje o que tenga un pasatiempo que involucre la exposición a plomo? (acabado de muebles, haciendo vidrio manchado, electrónicos, soldando, reparación automotriz, haciendo pesas o señuelos para pescar, cargando casquillos o balas en una escopeta, disparando armas, haciendo reparos o remodelaciones, pintando/desmontando pintura, juguetes antiguos o importados, y/o haciendo cerámica).	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
5) ¿A vivido cerca de un fundidor de plomo, planta de baterías u otra industria de plomo? (parque/explosivos, reparación de auto/exterior de auto, quitando o juntando cable/alambre, produciendo cables, cerámica, rango de disparos, fabrica de vidrio plomado, maquinaria/equipo industrial, maquinaria o reparación de joyas, mina de plomo, fabricante de pintura/pigmento, plomería, reparación de radiador, yunque de metal o baterías, hierro o metal, o fundidor derretido)	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
6) ¿Usa trastes cristalinos o de cerámica para cocinar, comer o beber?	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
Una respuesta positiva a estas preguntas <u>exige</u> obtener el nivel de plomo en la sangre. Por favor, recuerde que el nivel de plomo en la sangre es obligatorio a los 12 y 24 meses, aunque las respuestas no sean positivas. ¿Se obtuvo el nivel de sangre?	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No	Sí No
Iniciales de Personal que dio la entrevista							

**Firma de Personal:**


**PLEASE NOTE PROVIDERS ARE REQUIRED TO INTERPRET AND INITIATE CARE AS INDICATED**

**Nombre del Paciente:** \_\_\_\_\_

**Numero de ID:** \_\_\_\_\_