KAN Be Healthy - Early and Periodic Screening, Diagnostic, and Treatment Screening

ID number:

Name	Date of birth	Age	Date of screen

PHYSICAL GROWTH ***(An update of the growth chart is required at each screen.)***

T	**Weight** (lbs/kg)	%		**Head circumference** (Birth-24 months)
P	**Length** (cm/in) Birth-24 months		**Weight/length%**	cm/in
R	**Height** (cm/in) (2-20 years)			%
BP	**BMI***	%	Male ☐	Female ☐

*If the BMI is greater than or equal to 85%, recommend appropriate nutrition input and physical activity.

BENEFICIARY & FAMILY HISTORY

Refer to completed history form in chart. ☐	**Present concerns**
No changes in medical Hx unless indicated. ☐	
Patient currently in foster care, no previous Hx. ☐	**Medications**
Previous Hx reviewed from visit on:	
Allergies (food and drug)	**Serious illness/accidents** (If yes, date & type.) (including hospital or ER visits)
Birth history (measurements & complications)	**Operations** (If yes, date & type.)

Diseases & issues (Circle and indicate relationship: P - parent, G - grandparent, B - brother, S - sister, SELF.**)**

Asthma	Colds/sore throat	Epilepsy/seizures	Lung disease	Speech/visual/hearing
Birth defect	Diabetes	Headaches	Mental illness	Ulcers/colitis
Blood disorder/sickle cell	Drug or ETOH abuse	High blood pressure	Obesity	Urinary/bowel
Cancer	Earaches	Kidney/liver disease	Scoliosis/arthritis	Heart disease/stroke

BODY SYSTEMS (Check and comment appropriately.)

SYSTEMS	WNL	ABN	**Comments** (describe any abnormal findings)
General appearance			
Integumentary			
Head/neck			
Eyes/ears/nose/throat			
Oral/dental			
Pulmonary			Lung sounds?
Cardiovascular			Murmur?
Abdomen/gastrointestinal			
Genitourinary			Tanner score Menstrual bleeding evaluation Enuresis
Trunk/spine			
Musculoskeletal			
Neurological			

LAB/IMMUNIZATIONS (circle and complete as applicable)
Follow the recommended immunization schedule approved by the ACIP, AAP, and AAFP.

Copy of record in chart:	Parent requested	Referred to VFC provider	Current	Behind	Unknown
Immunizations given today:					
Obtain CBC with automated differential	Male – Age 15	Female – Time of menache	9-12 mos	Annual*	

**Required depending on lifestyle and health needs. Reference the KBH-EPSDT Provider Manual.*
Was CBC obtained? YES ☐ NO ☐ Indicate further follow-up in Plan of Care.

The Blood Lead Questionnaire is a separate document.	
☐ Negative screen	☐ Positive screen - draw blood level

VISION SCREEN

Ages 0-3: Corneal light reflex present YES ☐ NO ☐	**Ages 3-20** **Bruckner exam** Pass ☐ Refer ☐
All ages **Outer inspection**	**Distance acuity Score** L ______ R______ Both ______ Tool used
Eye tracking	**Near acuity Score** L ______ R______ Both ______ Tool used
Ocular motility (strabismus/cross cover test)	**Last exam**

DENTAL

It is recommended assessment preventative dental services and oral treatments begin at 6-12 months of age and repeat every 6 months or as needed.

Sees dentist? Yes ☐ No ☐	**Fluoride varnish?** Yes ☐ No ☐
Last dental exam date:	**Dental referral:**

HEARING SCREEN

Maintain in record completed paper hearing screens and report or qualifying hearing screen procedure and report.

Birth-4 years	Risk Indicators for Hearing Loss & Hearing Developmental Scales	Pass ☐ Refer ☐
4-21 years	Hearing Health History	Pass ☐ Refer ☐
Screen procedure		

NUTRITION

WIC participant ☐		**Referred to WIC** ☐
Formula ☐	**Breastfeeding** ☐	**Amount & frequency**

Number of servings per day

Bread/cereal	Fruit	Vegetable	Protein source	Dairy	Fat/sweet/sugar

Fluid intake per day (ounces)

Water	Milk	Soda	Juice

PHYSICAL ACTIVITY (circle all that apply)

Biking	Basketball	Skating	Walking	Other sports	Playing outside

DEVELOPMENTAL/EMOTIONAL ***Refer to the ACIP, AAP, and AAFP for recommended developmental tools.***

A completed developmental screening tool (indicate tool used): ______________________________

Birth-6 years	Include the screener's interpretation and report regarding meeting developmental milestones
6-21 years	Include the screener's interpretation and report or document all developmental/emotional below

Sleep habits		Tired/overactive?		Special education	
Discipline		Vocational concerns?		Special needs	
Grade level		Average grades		Exercise	
Emotional observations					

Pregnant? **NO** ☐ **YES** ☐ **If YES, complete the following:**

Prenatal vitamins? YES ☐ NO ☐	Prenatal record initiated? YES ☐ NO ☐	Referred for OB/GYN care? YES ☐ NO ☐
Referred to:		

HEALTH EDUCATION & ANTICIPATORY GUIDANCE (circle all that apply)

Behavior/discipline	Family planning	Parenting	Oral/dental	Development	Physical activity	Substance abuse	Nutrition
Self breast exam	Self testicular exam	Sexuality	Safety/poisons	Immunization	Weapon safety	Exercise	Lifestyle
Other							

RESULTS/PLAN OF CARE

Screening results
Plan/referrals (dental, vision, hearing, dietary)
Recommended return date

Parent/caregiver and/or patient informed of KBH - EPSDT screen findings and verbalizes understanding of findings and recommendations. YES ☐ NO ☐

Parent/caregiver or patient signature ______________________________ Date ______________

Screening provider signature ______________________________

A licensed physician, ARNP, PA, or registered nurse can perform KBH - EPSDT screens.