HealthWatch/EPSDT Guide

Indentifying information of child patient is on front of form.

Allergies _____NKA Please List: ____
Current Meds/Vitamins: ____
Height: ___________ Weight: __________ BP (age 3 and up): ___________ Pulse: ____________
Head Circ (0 - 24 mos)__________________ BMI: (9 mos to 20 yrs)________ Resp: _____________

Screenings:

Dental Screen: Observations: ____
Vision Screen: Corrected/Uncorrected (circle one) Left eye ____/_____ Right Eye ___/____
Physical Activity: ____
Hearing Screen: Within normal limits? YES/NO
Speech: Within Normal Limits? YES/NO **Nutritional Screen:** Adequate/Inadequate
Growth/Developmental Screen: Age Appropriate? YES/NO

Physical Examinations

Are These Normal?	Normal	Describe Abnormal Findings:
Skin/Hair/Nails Tuberculin Test		
Ears		
Eyes		
Nose/Mouth/Throat		
Teeth/Gums		
Head/Neck		
Respiratory		
Cardiovascular		
Abdomen/Gastrointestinal		
Endocrine		
Genitourinary/Breast (if applicable)		
Pelvic Exam (if applicable)		
Extremities/Musculoskeletal ROM		
Back/Hips		
Neurological		

Labs Ordered:

Lead Risk? YES/NO

Assessment Summary & Treatment Plan: Describe on front of form under "TREATMENT"

Immunizations due or administered during the visit:

Referrals:
❑WIC ❑Dental ❑Vision ❑Hearing ❑Developmental ❑Other (please specify on front of form)

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Clinician Printed Name *Signature on front of Record of Medical Treatment Form