

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

PATIENT INFORMATION																																				
Health Plan						Island of Residence					Indicate the EPSDT periodic screening age being reported												Type													
A	H	K	S	M	O	H	K	L	M	M	O	A	1	3	2	4	6	9	12	1	1	2	3	4	5	6	8	1	1	1	1	1	2	N	E	
C	Q	Q	U	A	T	I	A	A	A	O	A	d	d	m	m	m	m	m	m	m	5	8	y	y	y	y	y	y	0	2	4	6	8	0	W	S
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
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)												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)																								
APGAR		BIRTH WEIGHT - g				Mother's Medicaid/QUEST ID#						#																								
HISTORY FOR CHILDREN OLDER THAN 1 YEAR OF AGE: List below any significant illnesses, injuries, surgery, hospitalization, or applicable family history																																				
MEASUREMENTS																								Allergies		Medications										
Temperature-C or F				Blood Pressure				Height-cm				Weight-kg				BMI				Head Circ.-cm				<input type="radio"/>	<input type="radio"/>											
				/																				List:												
PHYSICAL EXAMINATION normal except as noted												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																								
SURVEILLANCE normal except as noted																																				
Vision/Hearing/Dental/Oral/ Development and Behavior, Lead & TB Assessment, Health Education, Counseling & Age Appropriate Anticipatory Guidance																																				
SCREENING done today																																				
												Y		N																						
Snellen/Allen ^{3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y 16y, 18y, 20y}												<input type="radio"/>		<input type="radio"/>																						
Audiogram (20-25 db screen) ^{4y-6y}												<input type="radio"/>		<input type="radio"/>																						
Blood Lead Level ^{9m - 12m, 2y}												<input type="radio"/>		<input type="radio"/>																						
Hgb/Hct ^{9m - 12m, Females-12y - 14y}												<input type="radio"/>		<input type="radio"/>																						
PPD ^{12m, 2-6y, 12-14 y}												<input type="radio"/>		<input type="radio"/>																						
Dev: PEDS/ASQ ^{9m, 12m, 18m, 2y, 3y, 4y, 5y}												<input type="radio"/>		<input type="radio"/>																						
Other Dev/Beh - List												<input type="radio"/>		<input type="radio"/>																						
DIAGNOSIS/STATUS																																				
<input type="radio"/> Well child						<input type="radio"/> Acute Illness						<input type="radio"/> CSHCN						List ICD-9 Codes of CSHCN																		
List Acute illness(es):																																				
REFERRALS MADE TODAY												<input type="radio"/> Y - indicate below						<input type="radio"/> N						Print names of specialists to whom referrals were made today												
<input type="radio"/> H-KISS		<input type="radio"/> DDD		<input type="radio"/> Cardiology		<input type="radio"/> Neurology		<input type="radio"/> Ophthalmology																												
<input type="radio"/> PHN		<input type="radio"/> Child Welfare		<input type="radio"/> Psychiatry or Psychology		<input type="radio"/> Otolaryngology		<input type="radio"/> Nephrology																												
<input type="radio"/> CAMHD		<input type="radio"/> DOE		<input type="radio"/> Orthopedics		<input type="radio"/> Gastroenterology		<input type="radio"/> Urology																												
<input type="radio"/> Developmental/Behavioral				<input type="radio"/> Dentistry				<input type="radio"/> Other(s)--list																												
CARE COORDINATION ASSISTANCE NEEDED												<input type="radio"/> Y - indicate below						<input type="radio"/> N						List additional information or other assistance needed												
<input type="radio"/> Arranging transportation				<input type="radio"/> Managing medical condition and/or medications																																
<input type="radio"/> Scheduling/Keeping appointments				<input type="radio"/> Coordinating multiple appointments																																
<input type="radio"/> Obtaining dental care				<input type="radio"/> Obtaining specialty services																																
<input type="radio"/> Obtaining foreign/sign language translation				<input type="radio"/> Other																																
<input type="radio"/> Written plan of care (POC) has been given to the family				<input type="radio"/> 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												<input type="radio"/> Y - indicate below						<input type="radio"/> N																		
<input type="radio"/> HepB		<input type="radio"/> DTaP		<input type="radio"/> IPV		<input type="radio"/> Hib		<input type="radio"/> Rotav		<input type="radio"/> PCV		<input type="radio"/> MMR																								
<input type="radio"/> Influenza		<input type="radio"/> Varicella		<input type="radio"/> HPV		<input type="radio"/> MCV4/MPSV4		<input type="radio"/> Tdap		<input type="radio"/> HepA		<input type="radio"/> Other(s)																								
List Other(s)												<input type="radio"/> Immunizations up to date						<input type="radio"/> 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		Provider Name (Print)						Signature						NPI #						Phone #																
Y																																				
<input type="radio"/>																																				