Orange County Head Start, Inc.
Empowering Children & Families

EHS

WELL CHECK FORM

PATIENT INFORMATION

Child's Name _____ Date of Birth _____

HEAD START follows the AAP Bright Futures EPSDT recommendations. Please do not leave any of the below sections blank.

PLEASE INDICATE WHICH WELL CHECK THIS IS (Provider Use Only):

☐ **3-5 DAYS** ☐ **1 MONTH** ☐ **2 MONTH** ☐ **4 MONTH** ☐ **6 MONTH**
☐ **9 MONTH** ☐ **12 MONTH** ☐ **15 MONTH** ☐ **18 MONTH** ☐ **24 MONTH** ☐ **30 MONTH**

TB SCREENING (REQUIRED at 1, 6, 12, & 24 MONTHS)

☐ **NOT at risk**

☐ **AT RISK** (Skin Test Required)
Results must be within last 12 months
Date Given: _____
Date Read: _____
Results: _____mm ☐ Negative ☐ Positive

NEWBORN SCREENINGS (REQUIRED BETWEEN 0-2 MONTHS)

Hearing Screening	Blood Screening
☐ Pass ☐ Fail	☐ Normal ☐ Abnormal
Bilirubin Test	**Heart Screening**
☐ Normal ☐ Abnormal	Critical congenital heart defect detected? ☐ No ☐ Yes

PHYSICAL EXAMINATION

Screening Requirement	Normal	Abnormal
General Appearance		
Blood Pressure		
Arms/Legs		
Eyes		
Ears		
Nose/Throat		
Skin		
Muscles/Bones/Joints		
Heart		
Lungs		
Urinary/Genitalia		
Stomach/GI		
Glands/Lymphatic/Thyroid		
Neurological/Cognitive		
Motor Ability		
Speech/Communication		

REQUIRED TESTS/EVALUATIONS

Growth Assessment: Length: _____ Weight: _____
Head Circumference (0-24 Month WC): _____
Dyslipidemia Screening (24 Month WC): ☐ Not at risk ☐ At Risk

Hemoglobin/Hematocrit (RISK ASSESSMENT AT 4, 15-30 MONTHS)
☐ NOT at risk ☐ AT RISK → RESULTS: _____
Iron Rx: ☐ Yes ☐ No Re-Check Due by: _____
Hemoglobin/Hematocrit (AT 12 MONTHS) → RESULTS: _____
Iron Rx: ☐ Yes ☐ No Re-Check Due by: _____

Lead Screening (REQUIRED AT 6-12, 18-24 MONTHS)
☐ NOT at risk ☐ AT RISK → LEAD VALUE: _____
Follow-Up Date: _____

Developmental Screening (9, 18, & 30 Month WC)
Appropriate developmental milestones for age?
☐ **Yes** ☐ **NO** **If no, indicate concerns/referrals below:**

Autism Screening (18 & 24 Month WC): ☐ No Concern ☐ Concern ☐ Referred
Referred to: _____

IF A CONCERN IS PRESENT, PLEASE EXPLAIN:

Behavioral/Social/Emotional Screening	No Concern	Concern
Oral Health Risk Assessment	No Concern	Concern
Fluoride varnish Applied?	Yes	No
Maternal Depression Screening	No Concern	Concern
Anticipatory guidance given?	Yes	No

Explain any abnormal findings and restrictions/recommendations for school:

NEXT EXAM DATE:

HEAD START STAFF ONLY

Date Received (Stamp):

PROVIDER USE ONLY

Office Stamp:

EXAM DATE:
Physician:
Phone/Fax:
Signature: