RECOMMENDATIONS FOR CHILD HEALTH CHECK-UPS (EPSDT)

●- To be performed S- Subjective by history O- Objective by testing A- At risk Δ- If not performed at school	INFANCY							EARLY CHILDHOOD						
	NEW BORN INPT	1 WEEK Optional	By 1 MONTH	2 MONTH	4 MONTH	6 MONTH	9 MONTH	12 MONTH	15 MONTH Optional	18 MONTH	24 MONTH	3 YRS	4 YRS	5 YRS
HISTORY														
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS														
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●			
Blood Pressure												●	●	●
BMI													●	●
SENSORY SCREENING														
Vision	●	S	●	●	●	O	<-O---------->		S	S	S	<---------O------->		
Hearing	●	S	S	S	S	S	S	S	S	S	S	S	O	Δ
DEVELOPMENTAL / BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL														
Hereditary / Metabolic Screening	●	Test if not previously tested												
Immunization	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin							<--●--------->		A	A	A	A	A	
Urinalysis														
PROCEDURES - PATIENTS AT RISK														
Lead Screening						S	<---------●->		S	S	●	Test if not previously tested		
Tuberculin Test								A	A	A	A	A	A	A
Cholesterol Screening											A	A	A	A
STD Screening														
Pelvic Exam														
ANTICIPATORY GUIDANCE														
Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Sleep Positioning Counseling	●	●	●	●	●	●								
Nutrition Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●	●
DENTAL REMINDER								<-------------------------------------●->					S	S

EFFECTIVE 2006

RECOMMENDATIONS FOR CHILD HEALTH CHECK-UPS (EPSDT)

	MIDDLE CHILDHOOD					ADOLESCENCE							
●- To be performed S- Subjective by history O- Objective by testing A- At risk Δ- If not performed at school	6 YRS	8 YRS	10 YRS	11 YRS Optional	12 YRS	13 YRS Optional	14 YRS	15 YRS Optional	16 YRS	17 YRS Optional	18 YRS	19 YRS Optional	20 YRS
HISTORY													
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS													
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference													
Blood Pressure	●	●	●	●	●	●	●	●	●	●	●	●	●
BMI	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING													
Vision	O	O	O	<-------------------- O -------------------->								S	S
Hearing	Δ	Δ	Δ	S	S	S	S	S	S	S	S	S	S
DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL													
Hereditary / Metabolic Screening													
Immunization	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin Menstruating Females				A	A	A	A	A	A	A	A	A	A
Urinalysis				A	A	A	A	A	A	A	A	A	A
PROCEDURES-PATIENTS AT RISK													
Lead Screening	Test if not previously tested												
Tuberculin Test	A	A	A	A	A	A	A	A	A	A	A	A	A
Cholesterol Screening	A	A	A	A	A	A	A	A	A	A	A	A	A
STD Screening				A	A	A	A	A	A	A	A	A	A
Pelvic Exam				A	A	A	A	A	A	A	A	A	A
ANTICIPATORY GUIDANCE													
Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●
Sleep Positioning Counseling													
Nutrition Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●
DENTAL REMINDER	S	S	S	S	S	S	S	S	S	S	S	S	S

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