REQUIRED FOR FOSTER CARE CHILDREN

WELL CHILD EXAM – EARLY CHILDHOOD: 12 Months

<table>
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<tr>
<th>DATE</th>
<th>CHILD’S NAME</th>
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Name and phone number of person who accompanied child to appointment:
Name: __________________________ Phone Number: __________________________

☐ Parent ☐ Foster Parent
☐ Relative Caregiver (specify relationship) ☐ Caseworker

Physical completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements

☐ Yes Please attach completed physical form utilized at this visit
☐ No If no, please state reason physical exam was not completed ________________________________

Developmental, Social/Emotional and Behavioral Health Screenings

Always ask parents or guardian if they have concerns about development or behavior. A developmental/behavioral assessment must be completed according to the recommendations of the AAP periodicity schedule. Screening for potential mental health issues may be accomplished by using an objective validated and standardized screening tool. A psychosocial/behavioral assessment must be completed at each scheduled well child visit and may be accomplished by surveillance or by using validated and standardized screening tools.

Validated Standardized Developmental Screening and Autism Screening completed: Date ________________

Screener Used: ☐ ASQ ☐ PEDS ☐ PEDSDM ☐ Other tool: ______________ Score: ______________

Referral Needed: ☐ No ☐ Yes

Referral Made: ☐ No ☐ Yes Date of Referral: ______________ Agency: ________________________________

Current or Past Mental Health Services Received: ☐ No ☐ Yes (if yes please provide name of provider)

Name of Mental Health Provider: ________________________________

EPSDT Abnormal results and Follow-up Needs:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc):

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Provider Signature: __________________________

Provider Name __________________________

Please print

This form was developed by the Institute for Health Policy at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Health and Human Services and Michigan Association of Health Plans.

Updated 4/2015