REQUIRED FOR FOSTER CARE CHILDREN
WELL CHILD EXAM-EARLY CHILDHOOD: 9 Months

DATE

CHILD’S NAME

DOB

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. An objective validated and standardized developmental screening must be completed at 9, 18 and 30 (or 24) months of age and when there are concerns. 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 □ ASQSE □ PEDS □ PEDSDM □ Other tool: ________________ Score: __________

Autism Screener Used: □ M-CHAT □ PDDST-II Score: □ Pass □ Fail

Referral Needed: □ No □ Yes Agency: ______________________________________________________________________

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.

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