Department of Children & Family Services
Building a Stronger Louisiana

LOUISIANA DEPARTMENT OF CHILDREN AND FAMILY SERVICES
CHILD HEALTH EXAMINATION FORM

CHILD'S NAME		PREFERRED NAME	DOB / /
SEX M / F	RACE	LANGUAGE	

VISIT TYPE: ☐ **MEDICAL SCREENING** ☐ **COMPREHENSIVE** ☐ **PROBLEM-FOCUSED**

HEALTH HISTORY

ALLERGIES			**MEDICATION**		
Significant birth history?	☐ No ☐Yes		Birth defects?	☐ No ☐Yes	
Failure to thrive?	☐ No ☐Yes		Speech delay/problem?	☐ No ☐Yes	
Developmental/learning problem?	☐ No ☐Yes		Behavioral/Mental health disorder?	☐ No ☐Yes	
Asthma?	☐ No ☐Yes		Passing out?	☐ No ☐Yes	
Heart problems?	☐ No ☐Yes		High blood pressure?	☐ No ☐Yes	
Blood disorders?	☐ No ☐Yes		Seizures?	☐ No ☐Yes	
Head injury?	☐ No ☐Yes		Bone/joint problems?	☐ No ☐Yes	
Ear/Hearing problems?	☐ No ☐Yes		Serious injury/illness?	☐ No ☐Yes	
Eye/Vision problems? ____ ☐ Glasses ☐ Contacts ☐ Other ____			Dental problems? ____ ☐ Braces ☐ Other ____		
Family history of sudden death before age 50?	☐ No ☐Yes		Hospitalizations? When? Why?	☐ No ☐Yes	
Family history of mental Health conditions?	☐ No ☐Yes		Surgeries? When? Why?	☐ No ☐Yes	

COMPLETED BY Signature ______________________ Printed Name ______________________

Relationship ______________________ Date ___/___/___

SCREENINGS

DEVELOPMENTAL

Screening Tool ____________

Results ☐ WNL ☐ Delay/Concern *(specify below)*

☐ Cognitive ☐ Communication
☐ Gross Motor ☐ Fine Motor
☐ Adaptive ☐ Social/Emotional
☐ Other ____________

Comments ____________

Currently Receives ECI Services
☐ No ☐ Yes ☐ Referred

MENTAL/BEHAVIORAL HEALTH

History of trauma?	☐ No ☐ Yes
Anxious?	☐ No ☐ Yes
Depressed?	☐ No ☐ Yes
Thoughts of harming self?	☐ No ☐ Yes
Thoughts of harming others?	☐ No ☐ Yes
Alcohol use?	☐ No ☐ Yes
Drug use?	☐ No ☐ Yes

Screening Tool ____________
Results ☐ WNL ☐ Concern
Comments ____________

SEXUAL/REPRODUCTIVE *(≥ 10 yr)*

Sexually active ☐ No ☐ Yes Number of partners _____
Partners ☐ Opposite sex ☐ Same sex ☐ Both
Safe sex practices ☐ No ☐ Yes
History STI ☐ No ☐ Yes Last STI test ___/___/___
Symptoms ☐ No ☐ Yes *(explain below)*
____
Menarche age ______ LMP ___/___/___
Gravida _____ Para _____
Contraceptives ☐ No ☐ Yes

Comments ____________

LEAD *(6 mo – 6 yr)*

Lead Risk Assessment *(Required annually 6 mo – 6 yr)*	☐ Not at risk ☐ At risk
Blood Lead Level *(Required at 1 yr, 2 yr and at risk)*	___/___/___ *Date drawn*

NUTRITION

<1 yr ☐ Breastfed ☐ Formula ____________ ☐ Solids ____________
>1 yr ☐ Well-balanced ☐ Needs ____________
Dietary Restrictions ☐ No ☐ Yes ____________
Comments ____________

HEARING

< 4 yr *(gross hearing)* ☐ WNL ☐ Abnormal
≥ 4 yr *(audiometry)* Right ☐ Pass ☐ Fail
Left ☐ Pass ☐ Fail

☐ Unable to test
☐ Referred
Comments ____________

VISION

< 3 yr *(gross vision)* ☐ WNL ☐ Abnormal
≥ 3 yr *(acuity screening)* Right ____/____
Left ____/____
Screened with corrective lenses ☐ No ☐ Yes
☐ Unable to test
☐ Referred
Comments ____________

DENTAL

Dental visit in past 12 months	☐ No ☐ Yes
Visible tooth decay	☐ No ☐ Yes
Urgent need for dental care *(pain, swelling, infection)*	☐ No ☐ Yes

☐ Referred
Comments ____________

*** COMPLETE BOTH SIDES ***

Department of Children & Family Services
Building a Stronger Louisiana

LOUISIANA DEPARTMENT OF CHILDREN AND FAMILY SERVICES
CHILD HEALTH EXAMINATION FORM

(TO BE COMPLETED BY MD/DO/APN/PA)

PHYSICAL EXAMINATION

Date Performed ______/______/______

☐ Physical Exam WNL ☐ Physical Exam Abnormal *(Please attach printed copy of EMR exam.)*

Height __________ cm (_______) percentile

Weight __________ kg (_______) percentile

BMI __________ kg/m² (_______) percentile

Head *(≤ 2 years)* Circumference __________ cm (_______) percentile

Blood Pressure *(≥ 3 years)* ________/________

Please document all abnormalities.

☐ General ____________________ ☐ Genitourinary ____________________

☐ HEENT ____________________ ☐ Musculoskeletal ____________________

☐ Cardiovascular ____________________ ☐ Integumentary ____________________

☐ Respiratory ____________________ ☐ Neurological ____________________

☐ Lymphatic ____________________ ☐ Other ____________________

☐ Gastrointestinal ____________________ ____________________

ASSESSMENT

DIAGNOSIS	ICD-10	CPT
☐ Well Child	Z00.129	________
☐ Well Child exam with abnormal findings *(List additional diagnoses below.)*	Z00.121	________
☐ ________	________	________
☐ ________	________	________
☐ ________	________	________
☐ ________	________	________
☐ ________	________	________

RECOMMENDATIONS

☐ Full physical activity ☐ Restrictions *(specify)* ____________________

☐ Treatment(s)/ Prescription(s) : ____________________

☐ Referral(s) : ____________________

Emergency Action Plan needed: *(asthma, seizures, allergy, bleeding, diabetes, etc.…)* ☐ No ☐ Yes *(If yes, please provide.)*

Follow-up care needed: ☐ No ☐ Yes Reason: ____________________ Date______/______/______

Immunizations: ☐ DTP/DTaP ☐ Tdap/Td/DT ☐ Polio ☐ Hep B ☐ Hib ☐ PCV ☐ MMR ☐ Varicella ☐ Rotavirus ☐ Meningococcal ☐ Hep A ☐ HPV ☐ Influenza ☐ Other ____________

MEDICAL PROVIDER

Signature	Facility
Print	Address
Date / /	Telephone ( ) -

** COMPLETE BOTH SIDES **