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| State_Seal3  To be completed by physician  Send this form to:  ADOPTION SUPPORT PROGRAM | | | | | | DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES  **EPSDT Assessment**  EARLY PERIODIC SCREENING, DIAGNOSIS,  AND TREATMENT (EPSDT) | | | | | | | | | 1. ASSESSMENT TYPE  Initial  Periodic | | 2. SCREENING DATE |
| 3. PATIENT IDENTIFICATION CODE (PIC) | | |
| 4. CHILD’S NAME | | | | | | | | | | | 5. DATE OF BIRTH | | | | 6. AGE | 7. FAMILY NAME | |
| 8. Is child currently in foster/group care placement?  Yes  No If yes, where: | | | | | | | | | | | | | | | | | |
| 9. SOCIAL WORKER’S NAME | | | | | | | | 10. OFFICE | | | | | | | | 11. TELEPHONE NUMBER | |
| **A. DEVELOPMENTAL ASSESSMENT** | | | | | | | | | | | | | | | | | |
| Include height, weight, head circumference, growth milestones, age appropriate cognitive abilities, motor development, etc. | | | | | | | | | | | | | | | | | |
| **B. IMMUNIZATION: ENTER DATE GIVEN AND OFFICE WHERE GIVEN** | | | | | | | | | | | | | | | | | |
|  | DATE | | | | OFFICE WHERE GIVEN | | | | | | | |  | OFFICE WHERE GIVEN | | | DATE |
| DPT |  | | | |  | | | | | | | | MMR |  | | |  |
| Polio |  | | | |  | | | | | | | | HIB |  | | |  |
| DT |  | | | |  | | | | | | | | HEPB |  | | |  |
| **C. LABORATORY TESTS: CHECK “NORMAL” OR DESCRIBE ABNORMAL RESULTS** | | | | | | | | | | | | | | | | | |
|  | | | DATE | | | | NORMAL | | | DESCRIBE ABNORMAL RESULTS | | | | | | | |
| Hematocrit | | |  | | | |  | | |  | | | | | | | |
| Sickle Cell | | |  | | | |  | | |  | | | | | | | |
| CBC | | |  | | | |  | | |  | | | | | | | |
| Urinalysis | | |  | | | |  | | |  | | | | | | | |
| Tuberculin | | |  | | | |  | | |  | | | | | | | |
| PKU/thyroid | | |  | | | |  | | |  | | | | | | | |
| Lead Screen | | |  | | | |  | | |  | | | | | | | |
| **D. LABORATORY TESTS: CHECK “NORMAL” OR DESCRIBE ABNORMAL RESULTS** | | | | | | | | | | | | | | | | | |
| NORMAL | | QUESTIONABLE | | ABNORMAL | | | OMIT | | TITLE | | | | | | | | |
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| **E. VISION ASSESSMENT (INCLUDE DATE GIVEN)** | | | | | | | | | | | | | | | | | |
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| **F. HEARING ASSESSMENT (INCLUDE DATE GIVEN)** | | | | | | | | | | | | | | | | | |
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| **G. DENTAL/ORAL ASSESSMENT (INCLUDE DATE GIVEN)** | | | | | | | | | | | | | | | | | |
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| **H. NUTRITIONAL STATUS** | | | | | | | | | | | | | | | | | |
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| **I. CHILDHOOD DISRUPTIONS** | | | | | | | | | | | | | | | | | |
| Children who have had childhood disruptions, experienced abuse or neglect, or been adopted often have emotional problems related to these disruptions in their development. Do you have concerns about this child’s mental health needs related to the following?  **If the answer is YES, please explain.**  Yes No  Emotions:  Behavior:  Development:  Family Situation:  Education:  Yes No  Do you recommend further assessment or services for any of the above indicated concerns?  Are there concerns regarding mental health or substance abuse?  Do you recommend further evaluation for mental health?  Do you recommend further evaluation for alcohol/substance abuse? | | | | | | | | | | | | | | | | | |
| COMMENTS: | | | | | | | | | | | | | | | | | |
| PRINT PROVIDER’S NAME | | | | | | | | | | | | PROVIDER’S SIGNATURE | | | | | |
| PROVIDER’S TAX IDENTIFICATION NUMBER | | | | | | | | | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | | | |