Hawaii Early And Periodic Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH-UP & FOLLOW-UP Form

PATIENT INFORMATION

Health Plan

AlohaCare	HMSA QUEST	Kaiser QUEST	Summerlin	Medicaid Fee-For Service	Other
O	O	O	O	O	O

Island of Residence

Hawaii	Kauai	Lanai	Maui	Molokai	Oahu
O	O	O	O	O	O

Today's Date (MMDDYY)	Name (Last, First, Middle Initial)	Medicaid ID#	Birthdate (MMDDYY)	M	F
		0 0 0 0		O	O

IMMUNIZATIONS GIVEN TODAY O Y- mark below O N

O HepB (Hepatitis B)	O DTaP (Diphtheria, Tetanus, Acelllular Pertussis)	O IPV (Inactivated Poliovirus)	O Hib (Haemophilus Influenza Type B)	O Rotav (Rotavirus)	O PCV (Pneumococcal)
O MMR (Measles, Mumps, Rubella)	O Tdap (Tetanus, Diphtheria, Acellular Pertussis)	O Varicella	O HPV (Human Papillomavirus)	O MCV4/MPSV4 (Meningococcal)	O Influenza
O HepA (Hepatitis A)	O Other(s)	List other(s)			
O Up to date	O Additional catch-up needed	Comments on catch up or immunization status			

SCREENING DONE OR REPEATED TODAY

Screening	Y	N
Snellen/Allen	O	O
Audio (20-25 db screen)	O	O
Blood Lead Level	O	O
Hgb/Hct	O	O
PPD	O	O
Dev: PEDS/ASQ	O	O
Other Dev/Beh - List	O	O

List abnormalities and/or concerns related to the screenings performed today and or abnormalities in Hgb/Hct, PPD, blood lead or screening results not previously noted during an EPSDT exam

FOLLOW-UP ON DIAGNOSIS(SES) AND TREATMENT O Y – indicate below O N

O Well child | O Acute Illness | O CSHCN

List ICD-9 Codes of CSHCN

_ _ _ . _ _ _ _ _ _ . _ _ _ _ _ _ . _ _ _

If "Y" list condition(s) and/or treatment follow-up provided today and/or new condition(s) identified today

FOLLOW UP AND/OR REFERRALS MADE TODAY O Y – indicate below O N

	Y	N
Agency(ies)	O	O
Specialtist(s)	O	O

If "Y" list agency(ies) and specialist(s). For follow-up, list results from previous referral(s)

CARE COORDINATION ASSISTANCE NEEDED O Y – indicate below O N

- O Bringing immunizations up to date
- O Arranging transportation
- O Scheduling/Keeping appointments
- O Obtaining foreign/sign language translation
- O Other

List additional information or other assistance needed

If assistance is needed, please provide parent's/caregiver's telephone no. to facilitate coordination _ _ _ - _ _ _ _

PROVIDER INFORMATION: By signing below I attest that the immunizations and screenings indicated above were given today by me or my staff under my supervision

Provider Name (Print)	Signature	NPI #	Phone #
			-