Washington State Department of Social & Health Services
CA Children's Administration

To be completed by physician
Send this form to:
ADOPTION SUPPORT PROGRAM

Division of Children and Family Services
EPSDT Assessment
EARLY PERIODIC SCREENING, DIAGNOSIS,
AND TREATMENT (EPSDT)

1. ASSESSMENT TYPE	2. SCREENING DATE
☐ Initial ☐ Periodic	
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
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	
☐	☐	☐	☐	

E. VISION ASSESSMENT (INCLUDE DATE GIVEN)

DSHS 10-083 (REV. 10/1998) (AC 03/2002)

F. HEARING ASSESSMENT (INCLUDE DATE GIVEN)

G. DENTAL/ORAL ASSESSMENT (INCLUDE DATE GIVEN)

H. NUTRITIONAL STATUS

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)

DSHS 10-083 (REV. 10/1998) (AC 03/2002)