KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Preventive Medical Care			POLICY #: 3.05-P		
DEPARTMENT: Health Services					
Effective Date: 06/2003	Review/Revised Date: 04/26/2016	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 4/26/18

Chief Financial Officer — Date 4/26/18

Chief Medical Officer — Date 4/23/18

Chief Operating Officer — Date 4/24/18

Director of Provider Relations — Date 4/16/18

Director of Member Services — Date 4/12/18

Administrative Director of Health Services — Date 4/12/18

POLICY:
Medi-Cal managed care health plans (MCPs) are contractually required to cover a wide range of preventive services and screenings in accordance with United States Preventive Services Task Force (USPSTF) grade "A" or "B" recommendations, as well as American Academy of Pediatrics/Bright Futures for members under the age of 21. USPSTF views immunizations as preventive services and recommends that all immunizations be provided as recommended by the Advisory Committee on Immunization Practices (ACIP). Kern Health Systems (KHS) will encourage

preventive care services for all members. Preventive care will be identified by KHS network providers. Preventive care for Medi-Cal members will include age appropriate Staying Healthy assessments, Initial Health Assessments (IHA), and CHDP services. IHA and CHDP visits are reimbursed per contract guidelines.

KHS will maintain and communicate preventive care protocols to providers. Preventive care will be provided in accordance with the following accepted guidelines:

- *The Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[1]
- *AAP Recommendations for Preventive Pediatric Health Care*
- *CHDP Medical Guidelines*
- *ACOG*

The presence of risk factors in individual patients will affect the type and quantity of preventive services that may be appropriate. Certain members may require additional services or core services at more frequent intervals.[2]

KHS is required to provide timely provision of recommended immunizations for both children and adults enrolled. KHS will provide childhood immunizations in accordance with the most recent childhood immunization schedule and recommendations published by ACIP4 for the Centers for Disease Control and Prevention (CDC). KHS's coverage obligation to provide adult immunizations is based on the ACIP-recommended immunizations included on the Medi-Cal FFS contract drug list as a pharmacy benefit.

KHS also allows all members to access local health departments (LHDs) for immunizations and for KHS to reimburse LHDs for the administration fee for immunizations administered to members, excluding immunizations for which the member is already up to date.

Preventive care will be provided in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources:

- CCR 17 §6800 et seq.
- California Code of Regulations Title 22 §53851(b)(1)
- DHCS Contract 03-76165 Attachment A – Exhibit 10 (3), (4), and (5)
- MCPB Letter 92-13: Initial Health Assessments
- MCPB Letter 92-16: Adult Preventive Health Screenings and Immunizations
- MMCD Policy Letter 96-12: Pediatric Preventive Services
- MMCD Policy Letter 96-13: Immunization Services in Medi-Cal Managed Care
- MMCD Policy Letter 99-07: Individual Health Education Behavioral Assessment
- MMCD All Plan Letter 07008: Topical Fluoride Varnish
- MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
- MMCD Policy Letter 13-001: Staying Healthy Assessments/Individual Health Education Behavioral Assessment

DEFINITIONS:

Adult	Individual 21 years of age and older[5].
Blood Lead Screening	"Screening" means testing an asymptomatic child for lead poisoning by analyzing the child's blood for concentration of Lead[3]

CHDP Program	Child Health and Disability Prevention Program. A preventive health program administered by Local Health Departments that provides periodic preventive health services to Medi-Cal children under the regulations of the Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.[4] A portion of the visits provided in accordance with the AAP guidelines will also qualify as CHDP visits.
Child	Individual under 21 years of age[5].
Initial Health Assessment	History and physical examination that is age and gender specific and includes the evaluation of immunization currency status, risk factors, socioeconomic environment, and health education needs.[6] This assessment must follow the USPSTF A and B recommendations for screening, testing, and counseling services for adults[7] and the AAP and CHDP guidelines for children.
Staying Healthy Assessment Tool	A patient self-administered tool that identifies health risks and thereby allows providers to conduct focused health care interventions.

PROCEDURES:

1.0 GENERAL ACCESS TO PREVENTIVE CARE SERVICES

KHS will ensure timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by ACIP, regardless of a member's age, sex, or medical condition, including pregnancy.

PCPs are required to ensure that all age and risk appropriate preventive services are provided to assigned members. As ACIP-recommended immunizations are viewed as preventive services, these services must not be subject to prior authorization. In instances where the Medi-Cal Provider Manual outlines immunization criteria that is less restrictive than ACIP criteria, KHS will provide the immunization in accordance with the less restrictive Medi-Cal Provider Manual criteria.7Members may schedule an appointment for preventive care (including an IHA) by calling their PCP. When a request is made for CHDP services, an appointment should be offered for the member to be examined within 2 weeks of the request.[8] If the member cannot be seen within the two week timeframe because the member refused offered appointments, such refusal should be documented. If the member encounters difficulty in scheduling an appointment, he/she may call KHS Member Services staff at 1-800-391-2000 for assistance.

Providers must document attempts to provide required preventive services, member contacts or attempted member contact, and any refusal of the services as outlined in *Section 3.0 Documentation* and its related subsections. Providers must document and appropriately follow-up on results of all required preventive services.

Title 16, California Code of Regulations (CCR), Section 1746.4(e) requires pharmacists to report the administration of any vaccine, within 14 days, to the appropriate immunization registry designated by the immunization branch of the State Department of Public Health. KHS will ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the KHS service areas as part of the Statewide Immunization Information System. Reports must be made following a member's IHA and after all other health care visits that result in an immunization, in accordance with state and federal laws. DHCS strongly recommends that not only pharmacists, but all KHS network providers, report immunization information within 14 days of

administering an immunization.

1.1 Initial Health Assessments - Access

An IHA must be provided to each member within the following timeframes:[9]

A. Members under the age of 18 months: Within 120[10] calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.[11]

B. Members 18 months of age and older: Within 120 calendar days of enrollment.

IHAs need not be performed if both of the following conditions are satisfied[12]:

A. The member's medical record contains complete information, updated within the previous 12 months, consistent with the KHS assessment requirements for the member's age group and gender

B. Based upon review of the prior medical record, the provider reviews and signs off in the medical record that the patient is current.

As PCPs receive their assigned patient panels, the Providers' offices should contact members to schedule an IHA to be performed within the time limit. If the provider/staff is unable to contact the member, he/she should contact KHS Member Services for assistance. In these cases, Member Services initiates attempts to contact the member via telephone and/or letter and coordinates with the PCP's office in an effort to secure a timely appointment. Contact attempts and results are documented by both the PCP and Member Services staff.[13]

1.2 Staying Healthy Assessments - Access

The initial Staying Healthy Assessment should be performed during the IHA[14]; thereafter, the PCP must re-administer the Staying Healthy Assessment at the appropriate age intervals.

Periodicity	**Initial SHA Administration**	**Subsequent SHA Administration**	**Subsequent SHA Administration**	**SHA Review**
Age Groups	Within 120 Days of Enrollment	After Entering New Age Group	Every 3 – 5 Years	Annually (intervening years between administration of new assessment)
0 – 6 Months	✓	✓		
7 - 12 Months	✓	✓		
1-2 Years	✓	✓		✓
3 – 4 Years	✓	✓		✓
5 – 8 Years	✓	✓		✓
9 – 11 Years	✓	✓		✓
12-17 Years	✓	✓		✓
Adult	✓		✓	✓
Senior	✓		✓	✓

It is strongly encouraged that members between the ages of 12 and 17 be re-assessed on an annual basis. Members over the age of 18 should be re-assessed every 3 to 5 years and more frequently for young adults.[15] Determination of the need for reassessment should be performed at each visit by review of the currency of the member's medical records. If a required

assessment is not appropriately documented in the patient's record, the PCP must provide the assessment during the current visit. If another PCP has conducted the assessment within the past 6 months, the provider may, with member consent, obtain the assessment records from the previous PCP.

1.3 Access to Follow-Up Services

All medically necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow-up.[16]

2.0 COVERED AND REQUIRED SERVICES

Preventive care should be provided in accordance with the current *Guide to Clinical Preventive Services Report (Report on the US Preventive Services Task Force)*[17], *AAP Recommendations for Preventive Pediatric Health Care*[18], and/or *CHDP Medical Guidelines* as appropriate. The frequency of periodic health examinations will not be increased for reasons which are unrelated to the member's medical needs, including a member's desire for additional physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.[19]

KHS will require their network providers to document each member's need for ACIP- recommended immunizations as part of all regular health visits, including, but not limited to the following types of encounters:

- Illness, care management, or follow-up appointments
- Initial Health Assessments (IHAs)
- Pharmacy services
- Prenatal and postpartum care
- Pre-travel visits
- Sports, school, or work physicals
- Visits to a LHD
- Well patient checkups Covered services include preventive health visits for children at times specified by the most recent AAP periodicity schedule. Where the AAP periodicity exam schedule is more frequent than the CHDP schedule, the AAP assessment must include all assessment components required by the CHDP for the lower age nearest to the current age of the child.[20]

At each non-emergency PCP encounter with members under the age of 21 years, the PCP must provide education to the member (if an emancipated minor) or the parent/guardian regarding:

A. The importance of pediatric preventive services and the timely receipt of these services[21]

B. The availability of CHDP services if the member has not received the services in accordance with the CHDP periodicity schedule[22]

2.1 Initial Health Assessment

At a minimum, Initial Health Assessments for adults must include the following[23]:

A. Comprehensive history that is sufficiently comprehensive to assess and diagnose acute and chronic conditions which includes, but is not limited to the following[24]:

  a. History of present illness

  b. Past medical history

    i. Prior major illness and injuries

ii. Prior operations
iii. Prior hospitalizations
iv. Current medications
v. Allergies
vi. Age appropriate immunization status
vii. Age appropriate feeding and dietary status

c. Social history
i. Marital status and living arrangements
ii. Current employment
iii. Occupational history
iv. Use of alcohol, drugs, and tobacco
v. Level of education
vi. Sexual history
vii. Any other relevant social factors

d. Review of organ systems

B. Weight/height data
C. Body Mass Index (BMI)
D. Blood pressure
E. Total serum cholesterol measurement for men ages 35 and over and women ages 45 and over
F. Clinical breast examination[25]
G. Mammogram or digital mammography for women (recommended every 2 years over the age of 40 and annually from age 50 to 75)
H. Pap smear (or arrangements made for performance) on all females within three years of becoming sexually active
I. Chlamydia screen for all sexually active females who are determined to be at high-risk for Chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age
J. Screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk
K. Staying Healthy Assessment

Assessments must also include those preventive health screens/tests which in the best clinical judgment of the provider are consistent with the plan's protocols for medical care, a discussion of appropriate preventive measures, and arrangements for future follow-up appointments as indicated.[26]

For those members under the age of 21, the appropriate CHDP assessment must be performed during the IHA. The IHA must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate health education behavioral assessment.[27]

The completed IHA or documentation of member/guardian refusal to complete the form must be included as part of the member's medical record and available during subsequent preventive health visits.[28]

2.2 Staying Healthy Assessments

The PCP must provide the member or parent/guardian if the member is under the age of 12, with the age and language appropriate form for completion. (See Attachment B). Separate

forms are available in both English and Spanish for the following ages:

A. 0 – 6 months
B. 7 – 12 months
C. 1 – 2 years
D. 3 – 4 years
E. 5 – 8 years
F. 9 – 11 years
G. 12-17 years
H. Adult
I. Senior

It is expected that the assessment forms will be completed by parents/guardians for children and self-completed by adolescents and adults.[29] If the member/parent/guardian requests assistance with completing the form, the PCP or office staff must provide assistance.

Members must be informed of their right to refuse to answer an assessment question or to complete the assessment. In the event that a member/parent/guardian refuses to complete the form, the PCP must document the refusal on the form and include it in the medical record.[30] The completed *Staying Healthy Assessment Tool* or documentation of member/guardian refusal to complete the form must be included as part of the member's medical record and available during subsequent preventive health visits.[31]

2.2.1 Risk Reduction Plan

The PCP must review the completed form with the member and develop a risk reduction plan. This plan must include targeted health education interventions, risk factors addressed, intervention codes, date, and PCP signature or initials.[32] The PCP must review the assessment tool and risk reduction plan at least annually with members who present for a scheduled visit.

2.3 Immunizations[33]

Providers are responsible for assuring that all members are fully immunized. Immunobiologics for Medi-Cal members are available and required for use by KHS Providers through the Vaccine for Children Program (VFC) and providers must participate in the VFC Program. KHS will inform providers of Vaccine for Children Program at orientations and as needed.

Children should be immunized in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Children should receive necessary immunizations at the time of any health care visit. If a child's immunizations cannot be given at the time of the visit, he/she must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

Adults should be immunized in accordance with the most current California Adult Immunization recommendations. In addition, providers are responsible for the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings, and/or the presence of risk factors identified in the Staying Healthy Assessment.

Prior to the administration of a vaccine set forth in the *Vaccine Injury Table*, (Attachment E) the provider must provide to the patient or legal representative of the patient a copy of the appropriate vaccine information materials published by the United States government, supplemented with visual presentations or oral explanations, in appropriate cases.[34] Camera ready copies of the Vaccine Information Statement materials are available on the Centers for Disease Control and Prevention's web-site at http://www.cdc.gov/nip/publications/vis.

PCPs are responsible for the tracking and documentation of immunizations for KHS plan members. The member's medical record should have a clearly designated area that identifies the member's immunization history and record. This should include documentation of the following:

A. All attempts to provide immunizations
B. Provision of instructions as to how to obtain necessary immunizations
C. The receipt of vaccines or proof of prior immunizations. For immunizations given, documentation must include manufacturer's name, lot number, the date vaccine is given and administering provider (as verified by PM160 for children). (See Attachment C).
D. Proof of any voluntary refusal of vaccines in the form of a signed statement by the member or responsible party. If the member or responsible party refuses to sign this statement, the refusal must be noted in the medical record.
E. Immunization record (PM298). (See Attachment D).
F. Date the Vaccine Information Statement (VIS) is provided to the member and its publication date[35].

2.4 Blood Lead Screening[36]

Providers must make reasonable attempts to ensure blood lead screening is provided at ages one and two in accordance with CCR Title 17 Section 37000. If blood lead screening is refused by the member, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor) or the parent or guardian must be documented in the medical record. If the responsible party refuses to sign this statement, the refusal must be noted in the medical record.

2.5 Chlamydia Screening[37]

Providers must screen all females through 25 years of age, who have been determined to be sexually active, for Chlamydia. Providers must make reasonable attempts to contact the appropriately identified members and provide screening for Chlamydia.[38] If Chlamydia screening is refused by the member, proof of voluntary refusal of the test in the form of a signed statement by the member (if an emancipated minor) or the parent or guardian must be documented in the medical record. If the responsible party refuses to sign this statement, the refusal must be noted in the medical record.

2.6 Clarification Regarding Mandated Benefits

The Federal and/or California State legislatures occasionally pass laws requiring health plans to cover specific medical services/treatments. Additional information is listed below regarding specific mandated benefits that qualify as preventive care.

2.6.1 Cancer Screening

KHS covers all generally medically accepted cancer screening tests that are requested and provided by a contracted provider or otherwise authorized provider.[39] Covered tests include but are not limited to the following:

A. Any cervical cancer screening tests approved by the Federal Food and Drug Administration.[40]

B. Mammography or Digital Mammography (recommended every 2 years over the age of 40 and annually from ages 50 to 75).

2.6.2 Human Papillomavirus (HPV)

KHS covers Gardasil for the prevention of cervical cancers. Effective on and after January 1, 2007 KHS will reimburse providers for this medically necessary preventive vaccine[41].

A. KHS recommends the HPV for routine immunizations for females 11 to 26 years of age and may be given as early as 9 years of age.

2.6.3 Topical Fluoride Varnish [42]

Effective for dates of service on or after June 1, 2006, HCPCS code D1203 (topical application of fluoride [prophylaxis not included], child) is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period. Physicians, nurses and medical personnel are legally permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes protocol.

2.7 Preventive Care Guide

KHS provides the *Preventive Care Guide* to Medi-Cal members as an educational tool in mailings. (See Attachment A).

3.0 GENERAL DOCUMENTATION

All children's preventive services must be documented on a *PM-160 Form.*[43] For all eligible children, the medical record must contain the following information regarding CHDP services:

A. Screening services provided and the associated results

B. Diagnosis and treatment services and results, including referral information if appropriate

C. Outreach and follow-up activities provided to ensure that members receive needed services

D. Encounter reporting

E. Notification of acceptance/denial of program by parent/guardian. Denial requires a statement signed by the parent/guardian. Refusal to sign statement must be noted in the medical record.[44]

Additional documentation requirements for a specific preventive service may be outlined in the relevant subsection of *Section 2.0 – Covered and Required Services.*

4.0 REIMBURSEMENT

Reimbursement for preventive care including Initial Health Assessment (IHA) is reimbursed at contracted rates. For the new Seniors and Persons with Disabilities (SPD) members enrolled from June 1, 2011 – May 31, 2012, additional reimbursement will be made for completing the IHA. A list of the new SPD members will be included with the new member lists that all PCP's receive at the beginning of each month. An additional $50 per completed IHA for SPD members will be paid on a quarterly basis. The payment amount will be determined based on paid claims during the quarter that

meet the criteria for IHA.

- Supplementary IHA payments for the SPD population must meet the following criteria:
- The SPD member must be newly enrolled into KHS for the period of June 1, 2011 to May 31, 2012.
- All IHA visits must occur within the member's first 120 days of enrollment.
- All members will receive a history and physical and be billed using the E&M codes listed in section 4.1 below.
- There will only be one supplementary payment per member. Payments will only be made to Primary Care Physicians assigned to a qualifying member.
- The supplementary IHA program will end on December 31, 2012.

4.1 Initial Health Assessments

The following table includes the procedure codes that should be used to document an IHA.

Exam	CPT Code
New patient	99381-99387 (Initial Preventive Medicine - age specific)
Established patient	99391-99397 (Periodic Preventive Medicine - age specific)

The following table includes the diagnosis codes that may be used to document an IHA.

Description
Health supervision of infant or child
Other healthy infant or child receiving care
Routine infant or child health check
Routine general medical examination at a health care facility
Health examination of defined subpopulations
Health examination in population surveys
Examination for normal comparison or control in clinical research
Other specified general medical examinations
Unspecified general medical examination

4.2 CHDP Visits, Tests, and Immunizations

The diagnosis code for all CHDP exams should be –listed as a Routine Child Health Exam. If the child is also seen for a specific condition, the specific diagnosis should also be listed on the claim. The following table includes the procedure codes that should be used to document a CHDP office visit.

Visit	CPT Code
New patient	99381-99385 (Initial Preventive Medicine - age specific)
Established patient	99391-99395 (Periodic Preventive Medicine - age specific)

The following table includes the procedure codes that should be used to document CHDP tests. Modifiers "ZS", "TC", or "26" must be included with lab tests.

Test	CPT Code
Chlamydia (*also used for IHA or annual exam)*	87110, 87270, 87320, 87491, 87492, 87810
GC Culture	87076
Hemoglobin, Hematocrit	85018, 85013
Hemogram	85025
Ova and parasites	87177
Pure Tone Audiometry	92552
Pure Tone Hearing Test	92551
Snellen Eye Test or equivalent visual acuity test	92081
TB test	86580
Urinalysis	81002, 81003
Urine dipstick	81000
VDRL, RPR, or ART	86592

Procedure codes that should be used to document immunizations are outlined in *Immunization Service Codes*. (See Attachment F). Immunobiologics for Medi-Cal members are available through the Vaccines for Children Program.[45] KHS only reimburses providers for administration of those vaccines available through the program.

5.0 PROVIDER REQUIREMENTS

Staying Healthy Assessments (including IHAs) may only be performed by PCPs or mid-level providers that are qualified to perform patient history and physicals.

6.0 PROVIDER RESOURCES

Staying Healthy Assessment Forms	May be requested from the KHS Provider Relations Department (661-664-5117). These forms may be photocopied. The forms are also available on the KHS website. (www.kernhealthsystems.com) and the DHCS website: (http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx) PCPs may contact KHS Provider Relations for technical assistance on using the form.

USPSTF Guide to Clinical Preventive Services	Available on the internet. www.uspreventiveservicestaskforce.org/

7.0 MONITORING and DELEGATION OVERSIGHT

KHS is responsible for ensuring that their delegates entities and subcontractors comply with all applicable state and federal law and regulations, as well as other contract requirements and DHCS guidance, including applicable APLs and Duals Plan Letters. These requirements must be communicated timely by KHS to all delegated entities and subcontractors to ensure timely compliance.

ATTACHMENTS:

Attachment A – *Preventive Care Guide*
Attachment B – *Staying Healthy Assessment Form*
Attachment C – *Immunization Record (PM298)*
Attachment D – *Vaccine Injury Table (Updated 2010-08)*
Attachment E – *Immunization Service Codes*

REFERENCE:

Revision 2018-02: Policy updated to comply with APL 18-004 by Administrative Director of Health Services. [1]**Revision 2015-06:** Policy updated for ICD 10 readiness by the Administrative Director of Health Services. ICD 9 Codes removed. **Revision 2014-06:** Policy approved by DHCS Health Education specialist May 2014. Revised by Health Education and Disease Management Manager to comply with Policy Letter 13.001 and DHCS MMCD SHA/IHEBA Review Checklist dated February 6, 2014.**Revision 2011-06:** New language stating that from June 1, 2011 – May 31, 2012, additional reimbursement will be made for completing the IHA for new Seniors and Persons with Disabilities (SPD) members. **Revision 2009-02:** DHCS Work Plan Deliverable 10A comments dated March 26, 2009. **Revision 2009-02:** DHS Work Plan Deliverable 10A Comments (11/13/08). **Revision 2008-08:** DHCS Work plan Deliverable 10.A dated 03/04/08. Added HPV recommendation and Digital Mammogram. **Revision 2006-01:** Revised per DHS Workplan Comments 10c dated 10/12/05. Revised per DHS Workplan Comments 10b dated 11/17/05. **Revision 2005-10:** Routine review. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2003-06**: Per DHS comment letter 03/04/03.

Title 16 CCR, Section 1746.4 (e)
[2] DHS Contract 03-76165 Exhibit A-10 (5)(B)(1)
DHS Contract §6.7.6.7. This language is not included in DHS Contract 03-76165.
[3] Title 17 CCR Section 37025
[4] MMCD Policy Letter 96-12, page 1
[5] MMCD Policy Letter 96-12, page 1. According to AAP guidelines, adults are ages 22 and older. Policy written to comply with MMCD definition.
[6] MCPB Letter 92-13, page 1
[7] Reference to "A" and "B" recommendations added per Workplan Comments 10A (11/13/08).
[8] DHS Contract 03-76165 Exhibit A-10 (4)(B)(3)
[9] DHS Contract 03-76165 Exhibit A-10 (4)(A) and (5)(A)
[10] DHCS Contract Amendment A17. Scope of Work, Attachment 10, 5 A(1)
[11] In Revision 2008-08, the timeframe was changed from 60 days to 120 days based upon MMCD Policy Letter 08-003. However, per Workplan Comments 10A (11/13/08), the Plan was instructed to change the timeframe back to 60 days. In Sep08, MMU was instructed that Plan contract timeframes take precedence over the MMCD Letter.
[12] CCR Title 22 Section 53851(b)(1)
[13] DHS Contract 03-76165 Exhibit A-10 (3)(D)
[14] DHS Contract 03-76165 Exhibit A-10 (3)(B)
[15] MMCD Policy Letter 99-07, page 3, page 5
[16] DHS Contract 03-76165 Exhibit A-10 (4) and (5)(B)(2)
[17] DHS Contract 03-76165 Exhibit A-10 (5)(B)(1)
[18] MMCD Policy Letter 96-12, page 2
[19] Language taken from HFAM 2006 – 2007 handbook.
[20] DHS Contract 03-76165 Exhibit A-10 (4)(B)(1) and (2)
[21] MMCD Policy Letter 96-12, page 4
[22] DHS Contract 03-76165 Exhibit A-10 (4)(B)(4)
[23] DHS Contract 03-76165 Exhibit A-10 (5)(A)
[24] MMCD Policy Letter 08-003 II(A). Added per Workplan comments 10A (11/13/08).
[25] Required by contract for women over age 40. KHS decision to require for all adults.
[26] MCPB Letter 92-13, page 1
[27] DHS Contract 03-76165 Exhibit A-10 (4)(3)
[28] DHS Contract 03-76165 Exhibit A-10 (3)(C); MMCD Policy Letter 99-07, page 3
[29] MMCD Policy Letter 99-07 (page 4)

[30] MMCD Policy Letter 99-07, page 2
[31] DHS Contract 03-76165 Exhibit A-10 (3)(C); MMCD Policy Letter 99-07, page 3
[32] MMCD Policy Letter 99-07, page 3
[33] DHS Contract 03-76165 Exhibit A-10 (4)(C) and (5)(C)
[34] USC Title 42 §300aa-26(d)
[35] Required per Facility Site Review Tool and MMCD Policy Letter 02-02.
[36] DHS Contract 03-76165 Exhibit A-10 (4)(D)
[37] DHS Contract 03-76165 Exhibit A-10 (4)(E)
[38] DHS Contract 03-76165 Exhibit A-10 (4)(E)
[39] Effective July 1, 2000
[40] HSC Section 1367.66; SB1219 Romero 2001; Effective 01/01/02
[41] MMCD Policy Letter 07015, October 18, 2007
[42] Added per Workplan Comments 10A (11/13/08)
[43] DHS Contract 03-76165 Exhibit A-10 (4)(B)(5)
[44] DHS Contract 03-76165 Exhibit A-10 (4)(B)(4)
[45] MMCD Policy Letter 96-13, page 5. Vaccines for Children program can be reached at (510) 843-0242 or (510) 540-2065. The address is as follows: 1918 University Avenue, Suite 2C, Berkeley, CA 94704.

Kern Family Health Care

The Friendly Face Of Kern Health Systems

(661) 632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield) • kernfamilyhealthcare.com

Preventive Care Guide

Take care of your health!

Kern Family Health Care wants you to get good health care. These preventive care guidelines help you stay healthy by preventing diseases or by finding them early on. Preventive care services are exams, screenings and immunizations that should be done on a regular basis.

These guidelines give preventive services by age groups. Use this guide to help you know what services should be done and when. Each age group lists the services recommended for that age such as; the Staying Healthy Assessment, Physical Exams, Dental Exams, Self Exams, Clinical Screenings and Immunizations[1]. Not all services are needed by everyone. Your doctor will help you know what services are right for you or your child. Your doctor can also help explain the services listed in these guidelines.

If you need more information, you can call your doctor. You can also call our 24-hour Advice Nurse Line toll free at: (661) 632-1590 (Bakersfield) or 1-800-391-2000 (outside of Bakersfield).

[1] The immunization schedule listed may have changed since this was printed. Please ask your doctor which immunizations are right for you or your child.

Si necesita esta información en Español, por favor llámenos.

Birth to 2 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form for your child between 0 to 3 years of age.*
Physical Exams	*Your baby should have a physical exam:* • Once as a newborn. • Once at 2-4 days of age. • Ten visits between 1 to 30 months of age. • Once a year after their second birthday.
Height, length, weight, BMI and head circumference	This should be done at every doctors visit.
Clinical Screenings	
Hemoglobin & Hematocrit	This should be done once at 9 to 12 months of age.
Lead Test	This should be done • Once at 10-12 months of age. • Once at 24 months of age.
TB Skin Test (PPD)	Children at high-risk are usually tested at 12 months of age. Ask your doctor if your child should be tested.
Autism	This should be done once at 18 months and once at 24 months.
Cholesterol Screening	Children at high-risk are usually tested at 24 months of age. Ask your doctor if your child should be tested.
Immunizations	
Hepatitis B	Three doses should be given to your baby. Infants may get their 1st dose soon after birth in the hospital. The 2nd dose at 2 months and 3rd dose at 6 to 18 months.
DTaP	Four doses should be given to your baby. The 1st dose at 2 months, 2nd dose at 4 months, 3rd dose at 6 months and 4th dose between 15 to 18 months.
Hib	Four doses should be given to your baby. The 1st dose at 2 months, 2nd dose at 4 months, 3rd dose at 6 months and 4th dose between 12 to 15 months.
Polio	Three doses should be given to your baby. The 1st dose at 2 months, 2nd dose at 4 months and 3rd dose between 6 to 18 months.
MMR	Your baby should get their 1st dose between 12 to 15 months.
Varicella (chickenpox)	Your baby should be immunized once between 12 to 15 months.
Pneumococcal (PCV)	Four doses should be given to your baby. The 1st dose at 2 months, 2nd dose at 4 months, 3rd dose at 6 months and 4th dose between 12 to 15 months.
PPSV	One dose is advised in addition to PCV for high-risk groups. The vaccine can be given starting at 24 months of age. Ask your doctor if your child needs this vaccine.
Hepatitis A	Two doses should be given to your child. The 1st dose at 1 year of age (12 to 23 months). The 2nd dose should be given 6 months apart.
Flu	One dose every fall for babies 6 to 23 months of age. Ask your doctor if your child needs this vaccine.
Rotavirus	Two or three doses should be given to your baby. The 1st dose at 2 months and a 2nd dose at 4 months. Some babies may need a 3rd dose at 6 months.
Meningococcal	One dose may be given at 2 years of age if your child is at high-risk. Ask your doctor if your child needs this vaccine.

DTaP = diphtheria, tetanus, pertussis (whooping cough) • Hib = haemophilus influenzae type b conjugate • MMR = measles, mumps, rubella
PCV = pneumococcal conjugate vaccine • PPSV = Pneumococcal polysaccharide vaccine

3 to 6 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form for your child between 4 to 8 years of age.*
Physical Exam	*Your child should have one physical exam every year.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*First dental exam due by age 3. One visit every year after.*
Clinical Screenings	
Blood Pressure	At every doctor's visit.
Urine Test	At age 5 or annually if child is high-risk.
Vision Test	At every physical exam.
Hearing Test	At every physical exam.
Lead Test	Once between ages 3 to 6 if no test was done during first 24 months of age.
TB Skin Test (PPD)	Once between the ages of 4 to 5.
Cholesterol Screening	At every physical exam if child is high-risk due to obesity, diabetes or positive family history.
Hemoglobin & Hematocrit	At every physical exam if child is high-risk due to obesity, diabetes or positive family history.
Immunizations	
Hepatitis B	Your child may begin a 3 dose series if it was missed.
DTaP	Your child should have their 5th dose between the ages of 4 to 6.
Polio	Your child should have their 4th dose between the ages of 4 to 6.
MMR	Your child should have their 2nd dose between the ages of 4 to 6.
Varicella (chickenpox)	Your child should have their 2nd dose between the ages of 4 to 6.
Pneumococcal (PCV)	May be given to children between 24-59 months of age if needed. Ask your doctor if your child needs this vaccine.
PPSV	May be given in addition to PCV for some high-risk groups. Ask your doctor if your child needs this vaccine.
Hepatitis A	Your child may begin a 2 dose series if not already given. The doses must be 6 months apart.
Flu	This vaccine may be given yearly up to age 5 or for high-risk groups. Ask your doctor if your child needs this vaccine.

DTaP = diphtheria, tetanus, pertussis (whooping cough) • MMR = measles, mumps, rubella
PCV = pneumococcal conjugate vaccine • PPSV = Pneumococcal polysaccharide vaccine

7 to 11 years...

(661) 632-1590 (Bakersfield) or
1-800-391-2000 (outside of Bakersfield)
9700 STOCKDALE HIGHWAY
BAKERSFIELD, CA 93311

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form for your child between 9 to 11 years of age.*
Physical Exam	*Your child should have one physical exam every year.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*Your child should have one visit every year.*
Clinical Screenings	
Blood Pressure	At every doctor's visit.
Cholesterol Screening	Every visit if child is high-risk due to obesity, diabetes or positive family history.
Urine Test	At every physical exam.
Vision Test	At every physical exam.
Hearing Test	At every physical exam.
Hemoglobin and Hematocrit	At every physical exam.
TB Skin Test (PPD)	Children at high risk should be routinely tested. Ask your doctor if your child should be tested.
Immunizations	
Hepatitis B	Your child may begin 3 dose series if it was missed.
Tdap	Your child should get one dose of this vaccine five years after the last DTaP. Dose may be given as early as 11 years of age.
MMR	Your child may begin 2 dose series if it was missed.
Varicella (chickenpox)	Your child may be given this vaccine if it was missed and if they have not had chickenpox. Ask your doctor if your child needs this vaccine.
Pneumococcal (PPSV)	This vaccine is recommended for some high risk-groups. Ask your doctor if your child needs this vaccine.
Hepatitis A	Your child may begin a 2 dose series if not already given. The doses must be six months apart.
Flu	This vaccine may be given yearly if your child is at high-risk. Ask your doctor if your child needs this vaccine.
HPV (females only)	Your child may begin a 3 dose series at the age of 11. The 2nd dose should be given 2 months after the 1st dose. The 3rd dose should be given 6 months after the 1st dose. Ask your doctor if your child needs this vaccine at the age of 9.
Meningococcal	Your child may receive 1 dose of this vaccine at age 11.

Tdap = tetanus, diphtheria, pertussis (whooping cough) • MMR = measles, mumps, rubella • PPSV = Pneumococcal polysaccharide vaccine
HPV = human papillomavirus

12 to 20 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form every year between the ages 12 to 17. Complete one form every five years after the age of 18.*
Physical Exam	*Once a year.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*Once a year.*
Clinical Screenings	
Blood Pressure	Every doctor's visit.
Cholesterol Screening	Every visit if you are at high-risk due to obesity, diabetes or positive family history.
Urine Test	At every physical exam.
Vision Test	Every 1 to 3 years.
Hearing Test	Every 1 to 3 years.
Hemoglobin and Hematocrit	Only for those individuals identified as high-risk. Check with your doctor if needed.
TB Skin Test (PPD)	Only for those individuals identified as high-risk. Check with your doctor if needed.
Women	
Pelvic Exam & Pap Smear	Check with your doctor if needed.
Chlamydia Screening	Every year if sexually active.
Men	
Clinical Testicular Exam	This will be done every year if indicated by health history or physical exam.
Immunizations	
Hepatitis B	You may be given a 3 dose series if it was not given to you before.
Tdap/Td	You will need 1 Tdap booster shot if it was not given at age 11 or 12 years. Routine Td booster shots are recommended every 10 years.
MMR	You may be given a 2 dose series if it was not given to you before.
Varicella (chickenpox)	May be given if missed, and if you have not had chickenpox. Two doses should be given four weeks apart if you are at risk. Ask your doctor if needed.
Pneumococcal (PPSV)	This vaccine is recommended for some high-risk groups. Ask your doctor if needed.
Hepatitis A	You may be given a 2 dose series if it was not given to you before. The doses must be six months apart.
Flu	This vaccine may be given yearly if you are at risk. Ask your doctor if needed.
HPV (females only)	You may be given a 3 dose series at the age of 12 if it was not given to you before. The 2nd dose should be given 2 months after the 1st dose. The 3rd dose should be given 6 months after the 1st dose.
Meningococcal	You may receive 1 dose of this vaccine if it was not given at age 11.

Td = tetanus, diphtheria • Tdap = tetanus, diphtheria, pertussis (whooping cough) • MMR = measles, mumps, rubella
PPSV = Pneumococcal polysaccharide vaccine • HPV = human papillomavirus

21 to 39 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form every 5 years.*
Physical Exam	*Every 1 to 3 years.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*Once a year.*
Self-Exams	
Women Breast Self Exam	Every month.
Men Testicular Self Exam	Every month.
Clinical Screenings	
Blood Pressure	Every doctor's visit.
Cholesterol Screening	Every year for those individuals identified as being high-risk. Men: once at 35 years of age.
Urine Test	Every 1 to 3 years.
Hemoglobin and Hematocrit	Only for those individuals identified as high-risk. Check with your doctor if needed.
Hearing Test	Every 1 to 3 years.
Vision Test	Every 1 to 3 years.
TB Skin Test (PPD)	Only for those individuals identified as high-risk. Check with your doctor if needed.
Women	
Pelvic Exam & Pap Smear	Every 2 to 3 years unless identified as high risk. Check with your doctor when needed.
Chlamydia Screenings	Every year if sexually active until age 25. Every year for those individuals Identified as high risk. Check with your doctor if needed.
Men	
Clinical Testicular Exam	This will be done every year if indicated by health history or physical exam.
Immunizations	*Adult immunizations to be given if routine immunizations are not up to date.*
Tdap/Td	You may need 1 Tdap booster shot. Routine Td booster shots are recommended every 10 years.
Flu	This vaccine may be given yearly if you are at risk. Ask your doctor if needed.
Pneumococcal	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.
Hepatitis B	You may be given 3 doses if you are at high-risk. It is also recommended for travelers. Ask your doctor if needed.
MMR	May be given if missed during childhood. One dose may be given if you have not had measles, mumps or rubella. Two doses should be given if you are at risk due to your job. Ask your doctor if needed.
Varicella (Chickenpox)	May be given if missed, and if you have not had chickenpox. Two doses should be given four weeks apart if you are at risk. Ask your doctor if needed.
Meningococcal	You may be given 1 dose if you are at high risk. Ask your doctor if needed.

Td = tetanus, diphtheria • Tdap = tetanus, diphtheria, pertussis (whooping cough) • MMR = measles, mumps, rubella

40 to 64 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form every 5 years.*
Physical Exam	*One visit every 1 to 2 years.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*Once a year.*
Self-Exams	
Women Breast Self Exam	Every month.
Men Testicular Self Exam	Every month.
Clinical Screenings	
Complete Skin Exam	At every physical exam.
Rectal Exam with Stool for Occult Blood	Every 3 to 5 years.
Sigmoidoscopy	Every 3 to 5 years for persons age 50 and over.
Blood Pressure	Every doctor's visit.
Cholesterol Screening	Every year for those individuals identified as being high-risk. Women: once at 45 years of age.
Urine Test	Every 2 years.
Hemoglobin and Hematocrit	Every 2 years.
Glucose Screening	Every 3 years beginning age 45.
Hearing Test	Every 1 to 3 years.
Vision Test	Every 1 to 3 years.
TB Skin Test (PPD)	Only for those individuals identified as high-risk. Check with your doctor if needed.
Women	
Pelvic Exam & Pap Smear	Every 3 years unless identified as high risk. Check with your doctor when needed.
Clinical Breast Exam	Every year.
Mammogram	Every 2 years at ages 40-49. Every year for individuals identified as high-risk and at ages 50 and older.
Osteoporosis Risk Assessment	Once every 2 years as part of physical exam.
Men	
Clinical Testicular Exam	Every year.
Prostate-Specific Antigen (PSA)	After age 50 as recommended by doctor.
Immunizations	*Adult immunizations to be given if routine immunizations are not up to date.*
Tdap/Td	You may need 1 Tdap booster shot. Routine Td booster shots are recommended every 10 years.
Flu	Everyone age 50 and older should have 1 dose yearly.
Pneumococcal	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.
Hepatitis B	You may be given 3 doses if you are at high-risk. It is also recommended for travelers. Ask your doctor if needed.
Varicella (chickenpox)	May be given if missed, and if you have not had chickenpox. Two doses should be given four weeks apart if you are at risk. Ask your doctor if needed.
Meningococcal	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.
Zoster	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.

Td = tetanus, diphtheria • Tdap = tetanus, diphtheria, pertussis (whooping cough)

over 64 years...

KFHC recommends...	How often should this be done?
Staying Healthy Assessment	*Complete one form every 5 years.*
Physical Exam	*One visit every 1 to 2 years.*
Height, weight, BMI	This should be done at every doctors visit.
Dental Exam	*Once a year.*
Self-Exams	
Women Breast Self Exam	Every month.
Men Testicular Self Exam	Every month.
Clinical Screenings	
Complete Skin Exam	At every physical exam.
Rectal Exam with Stool for Occult Blood	Every year.
Sigmoidoscopy	Every 3 to 5 years.
Blood Pressure	At least every 2 years.
Cholesterol Screening	Every 1 to 5 years.
Urine Test	Every 1 to 3 years.
Hemoglobin & Hematocrit	Every 2 years.
Glucose Screening	Every 3 years beginning age 45.
Hearing Test	Every 1 to 3 years.
Vision/Glaucoma Screening	Every 2 to 3 years.
TB Skin Test (PPD)	Only for those individuals identified as high-risk. Check with your doctor if needed.
Women	
Pelvic Exam & Pap Smear	Every 3 years unless identified as high risk. Check with your doctor when needed.
Clinical Breast Exam	Every year.
Mammogram	Every year.
Osteoporosis Risk Assessment	Once every 2 years as part of physical exam.
Men	
Clinical Testicular Exam	Every year.
Prostate-Specific Antigen (PSA)	As recommended by doctor.
Immunizations	*Adult immunizations to be given if routine immunizations are not up to date.*
Td	You will need 1 booster shot every 10 years.
Flu	You should have 1 dose every year.
Pneumococcal	You should have 1 dose after age 65.
Hepatitis B	You may be given 3 doses if you are at high-risk. It is also recommended for travelers. Ask your doctor if needed.
Varicella (chickenpox)	May be given if missed, and if you have not had chickenpox. Two doses should be given four weeks apart if you are at risk. Ask your doctor if needed.
Meningococcal	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.
Zoster	You may be given 1 dose if you are at high-risk. Ask your doctor if needed.

Td = tetanus, diphtheria

Kern Family Health Care
La Cara Amable
De Kern Health Systems

(661) 632-1590 (Bakersfield) o 1-800-391-2000 (fuera de Bakersfield) • kernfamilyhealthcare.com

Guía Preventiva de Salud

¡Cuide su salud!

Kern Family Health Care quiere que usted tenga el mejor cuidado de salud. Esta guía preventiva le ayudara a mantenerse saludable mediante la prevención de enfermedades o su descubrimiento en una etapa temprana. Los servicios de cuidados preventivos son exámenes médicos, análisis y vacunas que se deben realizar de manera regular.

Esta guía describe servicios preventivos por grupo de edad. Use esta guía para que le ayude a conocer qué servicios se deben realizar y cuándo. Cada grupo de edad enumera los servicios que se recomiendan para esa edad, tales como el cuestionario Manténgase o Mantenga a su Niño Saludable, Exámenes Físicos, Exámenes Dentales, Auto Exámenes, Análisis Clínicos y Vacunas[1]. No todos los servicios son necesarios para todos. Su médico le ayudará a conocer que servicios son apropiados para usted o para su niño. Su médico también le podrá explicar los servicios enumerados en esta guía preventiva.

Si usted necesita más información, puede llamar a su médico. Usted también puede llamar gratis a nuestra Línea de Enfermeras Consultantes disponibles las 24 horas al (661) 632-1590 (Bakersfield) o 1-800-391-2000 (fuera de Bakersfield).

[1] El programa de vacunación podría haber cambiado desde esta publicación. Por favor pregúntele a su médico qué vacunas son apropiadas para usted o para su niño.

If you need this information in English, please call us.

Nacimiento hasta los 2 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantenga a Su Niño Saludable"	*Llene un cuestionario para su niño entre 0 y 3 años de edad.*
Exámenes Físicos	*Su bebé debería ser sometido a un examen físico:* • Una vez como recién nacido. • Una vez entre los 2 y 4 días de edad. • Diez visitas entre 1 y 30 meses de edad. • Una vez por año después de su segundo cumpleaños.
Estatura, Peso, BMI y circunferencia de la de la cabeza	Esto debería hacerse en cada visita al médico.
Análisis Clínicos	
Hemoglobina y Hematocritos	Esto debería hacerse una vez entre los 9 y 12 meses de edad.
Prueba de Plomo	Esto debería hacerse: • Una vez entre los 10 y 12 meses de edad. • Una vez a los 24 meses de edad.
Prueba Cutánea de Tuberculosis	Los niños en alto riesgo son sometidos a la prueba a los 12 meses de edad. Pregunte a su médico si su niño debe ser sometido a la prueba
Prueba de Autismo	Esto debería hacerse una vez a los 18 meses de edad y una vez a los 24 meses de edad.
Prueba de Colesterol	Los niños en alto riesgo son sometidos a la prueba a los 24 meses de edad. Pregunte a su médico si su niño debe ser sometido a la prueba.
Vacunas	
Hepatitis B	A su bebé se le deben aplicar tres dosis. Los bebés pueden recibir su 1ra dosis inmediatamente después de nacer en el hospital. La 2da dosis a los 2 meses, y 3ra dosis entre los 6 y 18 meses de edad.
DTaP	A su bebé se le deben aplicar cuatro dosis. La 1ra dosis a los 2 meses, 2da dosis a los 4 meses, 3ra dosis a los 6 meses, y 4ta dosis entre los 15 y 18 meses de edad.
Hib	A su bebé se le deben aplicar cuatro dosis. La 1ra dosis a los 2 meses, 2da dosis a los 4 meses, 3ra dosis a los 6 meses, y 4ta dosis entre los 12 y 15 meses de edad.
Polio	A su bebé se le deben aplicar tres dosis. La 1ra dosis a los 2 meses, 2da dosis a los 4 meses y 3ra dosis entre los 6 y 18 meses de edad.
MMR	A su bebé se le debe aplicar la 1ra dosis entre los 12 y 15 meses.
Varicela	Su bebé debe ser vacunado una vez entre los 12 y 15 meses.
Neumococo (PCV)	A su bebé se le deben aplicar cuatro dosis. La 1ra dosis a los 2 meses, 2da dosis a los 4 meses, 3ra dosis a los 6 meses, y 4ta dosis entre los 12 y 15 meses de edad.
PPSV	Se recomienda una sola dosis además del PCV para grupos de alto riesgo. La vacuna puede ser aplicada a partir de los 24 meses de edad. Pregunte a su médico si su niño necesita esta vacuna.
Hepatitis A	A su bebé se le deben aplicar dos dosis. La 1ra dosis a 1 año de edad (12 a 23 meses). La 2da dosis se debe aplicar con seis meses de diferencia.
Gripe	Una dosis cada otoño para los bebés de 6 a 23 meses de edad. Pregunte a su médico si su niño necesita esta vacuna.
Rotavirus	Dos o tres dosis se le deben aplicar a su bebé. La primera dosis a los 2 meses y una segunda dosis a los 4 meses de edad. Algunos bebés pueden necesitar una tercera dosis a los 6 meses de edad.
Meningocócica	Una dosis se puede aplicar a los 2 años de edad si su bebé es de alto riesgo. Pregúntele a su médico si su niño necesita ésta vacuna.

DTaP = difteria, tétano y tos ferina • Hib = Vacuna conjugada contra el Haemophilus influenzae tipo B
MMR = sarampión, paperas y rubéola • PCV = neumocócica conjugada • PPSV = vacuna polisacárida contra el neumococo

de 3 a 6 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantenga a Su Niño Saludable"	*Llene un cuestionario para su niño entre los 4 a los 8 años de edad.*
Examen Físico	*Su niño debería ser sometido a un examen físico todos los años.*
Estatura, Peso, MI	Esto debería hacerse en cada visita al médico.
Examen Dental	*El primer examen dental se debe realizar a los 3 años de edad. Una visita todos los años a partir de esa edad.*
Análisis Clínicos	
Presión Sanguínea	En cada visita al médico.
Análisis de Orina	A los 5 años de edad o anualmente si su niño es de alto riesgo.
Prueba de Visión	En cada examen físico.
Prueba de Audición	En cada examen físico.
Prueba de Plomo	Una vez entre las edades de 3 a 6 años si no se ha hecho una prueba durante los primeros 24 meses de edad.
Prueba Cutánea de Tuberculosis	Una vez entre los 4 y 5 años de edad.
Prueba de Colesterol	En cada examen físico si el niño está en alto riesgo debido a obesidad, diabetes o historia familiar positiva.
Hemoglobina y Hematocritos	En cada examen físico si su niño es de alto riesgo debido a obesidad, diabetes o historia familiar positiva.
Vacunas	
Hepatitis B	Se puede comenzar una serie de tres dosis si la vacunación no se realizó.
DTaP	Su niño debería recibir una 5ta dosis entre las edades de 4 a 6 años.
Polio	Su niño debería recibir una 4ta dosis entre las edades de 4 a 6 años.
MMR	Su niño debería recibir una 2da dosis entre las edades de 4 a 6 años.
Varicela	Su niño debería recibir una 2da dosis entre las edades de 4 a 6 años.
Neumococo (PCV)	Puede ser aplicada a niños de entre 2 años y menos de 5 años de edad si fuera indicado. Pregunte a su médico si es necesaria.
PPSV	Esta vacuna se recomienda además de PCV para algunos grupos en alto riesgo. Pregunte a su médico si es necesaria.
Hepatitis A	Su niño puede comenzar una serie de 2 dosis si aún no se le ha aplicado. Las dosis se deben dar con seis meses de diferencia.
Gripe	Esta vacuna se puede aplicar una vez al año hasta los 5 años de edad o para los grupos de alto riesgo. Pregunte a su médico si su niño necesita esta vacuna.

DTaP = difteria, tétano y tos ferina • MMR = sarampión, paperas y rubéola
PCV = neumocócica conjugada • PPSV = vacuna polisacárida contra el neumococo

de 7 a 11 años...

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KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantenga a Su Niño Saludable"	*Llene un cuestionario para su niño entre los 9 y 11 años de edad.*
Examen Físico	*Su niño debería ser sometido a un examen físico todos los años.*
Estatura, Peso, BMI	Esto debería hacerse en cada visita al médico.
Examen Dental	*Su niño debería asistir a una visita todos los años*
Análisis Clínicos	
Presión Sanguínea	En cada visita al médico.
Prueba de Colesterol	En cada visita si el niño está en alto riesgo debido a obesidad, diabetes o historia familiar positiva.
Análisis de Orina	En cada examen físico.
Prueba de Visión	En cada examen físico.
Prueba de Audición	En cada examen físico.
Hemoglobina y Hematocritos	En cada examen físico.
Prueba Cutánea de Tuberculosis	Los niños con alto riesgo deberían ser sometidos a la prueba como rutina. Pregunte a su médico si su niño debe ser sometido a la prueba.
Vacunas	
Hepatitis B	Su niño puede comenzar con una serie de tres dosis si aun no se le aplicó.
Tdap	Su niño debe recibir una dosis de esta vacuna 5 años después de la última DTaP. La dosis se puede aplicar tan pronto como a los 11 años de edad.
MMR	Su niño puede comenzar con una serie de dos dosis si aun no se le aplicó.
Varicela	Se puede aplicar si no se lo ha hecho antes, y si su niño no ha tenido Varicela. Pregunte a su médico si su niño necesita esta vacuna.
Neumococo (PPSV)	Esta vacuna se recomienda para algunos grupos en alto riesgo. Pregunte a su médico si su niño necesita esta vacuna.
Hepatitis A	Su niño puede comenzar una serie de dos dosis si aún no se la ha aplicado. Las dosis deben separarse 6 meses entre una y otra.
Gripe	Esta vacuna se puede aplicar anualmente si usted esta en alto riesgo. Pregunte a su médico si es necesaria.
VPH (HPV) – solo para mujeres	Su niña puede comenzar una serie de tres dosis a los 11 años de edad. La 2da dosis se debe aplicar a los 2 meses después de la 1ra dosis. La 3ra dosis se debe aplicar 6 meses después de la 1ra dosis. Pregúntele a su médico si su niña necesita esta vacuna a los 9 años de edad.
Meningocócica	Su niño puede recibir 1 dosis de esta vacuna a los 11 años de edad.

Tdap = difteria, tétano y tos ferina (tos convulsiva) • MMR = sarampión, paperas y rubéola
PPSV = vacuna polisacárida contra el neumococo • HPV = virus papiloma humano

de 12 a 20 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantente Saludable"	*Llene un cuestionario cada año entre los 12 y 17 años de edad. Llene un cuestionario cada cinco años después de los 18 años de edad.*
Examen Físico	*Una vez por año.*
Estatura, Peso, BMI	Esto debería hacerse en cada visita al médico.
Examen Dental	*Una vez por año.*
Análisis Clínicos	
Presión Sanguínea	En cada visita al médico.
Prueba de Colesterol	En cada visita si usted está en alto riesgo debido a obesidad, diabetes o historial familiar positiva.
Análisis de Orina	En cada examen físico.
Prueba de Visión	De 1 a 3 años.
Prueba de Audición	De 1 a 3 años.
Hemoglobina y Hematocritos	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Prueba Cutánea de Tuberculosis	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Mujeres	
Examen de la Pelvis y Papanicolaou	Pregunte a su médico si es necesario.
Prueba de Clamidia	Todos los años si es sexualmente activa.
Hombres	
Examen Clínico de los Testículos	Esto se hará todos los años si fuera indicado por el historial clínico o examen físico.
Vacunas	
Hepatitis B	Se puede comenzar una serie de tres dosis si la vacunación no se realizó.
Tdap/Td	Necesitará una inyección de refuerzo Tdap si no se le dio a los 11 o 12 años. Se recomiendan vacunas rutinarias de refuerzo de Td cada 10 años.
MMR	Se puede comenzar una serie de dos dosis si la vacunación no se realizó.
Varicela	Se puede aplicar si no se lo ha hecho antes, y si la persona no ha tenido Varicela. Se deben aplicar dos dosis separadas por 4 semanas una de otra si usted está en alto riesgo. Pregunte a su médico si es necesaria.
Neumococo (PPSV)	Esta vacuna se recomienda para algunos grupos en alto riesgo. Pregunte a su médico si es necesaria.
Hepatitis A	Se puede comenzar una serie de dos dosis si aún no se la ha aplicado. Las dosis deben separarse 6 meses entre una y otra.
Gripe	Esta vacuna se puede aplicar anualmente si usted está en alto riesgo. Pregunte a su médico si es necesaria
VPH (HPV) – solo para mujeres	Se puede comenzar una serie de tres dosis a los 12 años si aún no se le ha aplicado. La 2da dosis se debe aplicar a los 2 meses después de la 1ra dosis. La 3ra dosis se debe aplicar 6 meses después de la 1ra dosis.
Meningocócica	Puede recibir 1 dosis de esta vacuna si no se le dio a los 11 años de edad.

Td = tétano y difteria • Tdap = difteria, tétano y tos ferina (tos convulsiva) • MMR = sarampión, paperas y rubéola
PPSV = vacuna polisacárida contra el neumococo • VPH = virus papiloma humano

de 21 a 39 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantente Saludable"	*Llene un cuestionario cada 5 años.*
Examen Físico	*Cada 1 a 3 años.*
Estatura, Peso, BMI	Esto debería hacerse en cada visita al médico.
Examen Dental	*Una vez por año.*
Auto exámenes	
Mujeres Auto examen de Senos	Todos los meses.
Hombres Auto examen de Testículos	Todos los meses.
Análisis Clínicos	
Presión Sanguínea	En cada visita al médico.
Prueba de Colesterol	Cada año para aquellas personas identificadas como de alto riesgo. Hombres: Una vez a los 35 años de edad.
Analisis de Orina	De 1 a 3 años.
Hemoglobina y Hematocritos	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Prueba de Audición	De 1 a 3 años.
Prueba de Visión	De 1 a 3 años.
Prueba Cutánea de Tuberculosis	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Mujeres	
Examen de la Pelvis y Papanicolaou	Cada 2 a 3 años a menos que sea identificada como de alto riesgo. Pregunte a su médico si es necesario.
Prueba de Clamidia	Todos los años si es sexualmente activa hasta los 25 años de edad. Cada año para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Hombres	
Examen Clínico de Testículos	Esto se hará todos los años si fuera indicado por el historial clínico o examen físico.
Vacunas	*Las vacunas se deben aplicar a los adultos si las vacunas de rutina no están al día.*
Tdap/Td	Puede que necesite una inyección de refuerzo Tdap. Se recomiendan vacunas rutinarias de refuerzo de Td cada 10 años.
Gripe	Esta vacuna se puede aplicar anualmente si usted está en alto riesgo. Pregunte a su médico si es necesaria.
Neumococo	Una dosis para aquellos que están en alto riesgo. Pregunte a su médico si es necesaria.
Hepatitis B	Se recomiendan tres dosis para adultos que están en alto riesgo. Se recomienda también para los viajeros. Pregunte a su médico si es necesaria.
MMR	Se puede aplicar si la vacunación no se realizó durante la niñez. Se puede aplicar una dosis si la persona no tuvo sarampión, paperas o rubéola. Se deben aplicar dos dosis a las personas que por su ocupación estén expuestas. Pregunte a su médico si es necesaria.
Varicela	Se puede aplicar si no se lo ha hecho antes, y si la persona no ha tenido Varicela. Se deben aplicar dos dosis separadas por 4 semanas una de otra si usted está en alto riesgo. Pregunte a su médico si es necesaria.
Meningocócica	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.

Td = tétano y difteria • Tdap = difteria, tétano y tos ferina (tos convulsiva)MMR = sarampión, paperas y rubéola

de 40 a 64 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantente Saludable"	*Llene un cuestionario cada 5 años.*
Examen Físico	*Una vez cada 1 a 2 años.*
Estatura, Peso, BMI	Esto debería hacerse en cada visita al médico.
Examen Dental	*Una vez al año.*
Auto exámenes	
Mujeres Auto examen de Senos	Todos los meses.
Hombres Auto examen de Testículos	Todos los meses.
Análisis Clínicos	
Examen Completo de la Piel	En cada examen físico.
Examen Rectal con Análisis de Material Fecal para Detectar Sangre Oculta	De 3 a 5 años.
Sigmoidoscopía	De 3 a 5 años para personas de 50 o más años de edad.
Presión Sanguínea	En cada visita al médico.
Prueba de Colesterol	Cada año para aquellas personas identificadas como de alto riesgo. Mujeres: Una vez a los 45 años de edad.
Análisis de Orina	Cada 2 años.
Hemoglobina y Hematocritos	Cada 2 años.
Análisis de Glucosa	De 3 años comenzando a los 45 años de edad.
Prueba de Audición	De 1 a 3 años.
Prueba de Visión	De 1 a 3 años.
Prueba Cutánea de Tuberculosis	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Mujeres	
Examen de la Pelvis y Papanicolaou	Cada 3 años a menos que sea identificada como de alto riesgo. Pregunte a su mádico si es necesario.
Examen Clínico de Senos	Todos los años.
Mamografía	Cada dos años entre las edades 40 a 49. Cada año para aquellas personas identificadas como de alto riesgo y a los 50 años y mayores.
Evaluación de Riesgo de Osteoporosis	Una vez cada 2 años como parte de un examen físico.
Hombres	
Examen Clínico de Testículos	Todos los años.
Antígeno Prostático Específico (PSA)	Después de los 50 años de edad según recomendaciones del médico.
Vacunas	*Las vacunas se deben aplicar a los adultos si las vacunas de rutina no están al día.*
Tdap/Td	Puede que necesite una inyección de refuerzo Tdap. Se recomiendan vacunas rutinarias de refuerzo de Td cada 10 años.
Gripe	Todas las personas de 50 o más años de edad deberían aplicarse una dosis anual.
Neumococos	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.
Hepatitis B	Se recomiendan tres dosis para adultos que están en alto riesgo. Se recomienda también para los viajeros. Pregunte a su médico si es necesaria.
Varicela	Se puede aplicar si no se lo ha hecho antes, y si la persona no ha tenido Varicela. Se deben aplicar dos dosis separadas por 4 semanas una de otra si usted está en alto riesgo. Pregunte a su médico si es necesaria.
Meningocócica	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.
Zóster	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.

Td = tétano y difteria • Tdap = difteria, tétano y tos ferina (tos convulsiva)

mayores de 64 años...

KFHC le recomienda...	¿Con qué frecuencia debería hacerse esto?
Cuestionario "Mantente Saludable"	*Llene un cuestionario cada 5 años.*
Exámenes Físicos	*Una vez cada 1 a 2 años.*
Estatura, Peso, BMI..................................	Esto deberla hacerse en cada visita al médico.
Exámen Dental	*Una vez al año.*
Auto exámenes	
Mujeres Auto examen de Senos	Todos los meses.
Hombres Auto examen de Testlculos	Todos los meses.
Análisis Clínicos	
Examen Completo de la Piel......................	En cada examen físico.
Examen Rectal con Análisis de Materia Fecal para Detectar Sangre Oculta..............	Todos los años.
Sigmoidoscopla..	De 3 a 5 años.
Presión Sangulnea....................................	Como mínimo cada 2 años.
Prueba de Colesterol................................	De 1 a 5 años.
Análisis de Orina.....................................	De 1 a 3 años.
Hemoglobina y Hematocritos.......................	Cada 2 años.
Análisis de Glucosa..................................	Cada 3 años comenzando a los 45 años de edad.
Prueba de Audición...................................	De 1 a 3 años.
Examen Ocular/Detección de Glaucoma.......	De 2 a 3 años.
Prueba Cutánea de Tuberculosis.................	Solamente para aquellas personas identificadas como de alto riesgo. Pregunte a su médico si es necesaria.
Mujeres	
Examen de la Pelvis y Papanicolaou............	Cada 3 años a menos que sea identificada como de alto riesgo. Pregunte a su mádico si es necesario.
Examen Clínico de Senos...........................	Todos los años.
Mamografía...	Todos los años.
Evaluación de Riesgo de Osteoporosis.........	Una vez cada 2 años como parte de un examen físico.
Hombres	
Examen Clínico de Testlculos.....................	Todos los años.
Antlgeno Prostático Especlfico (PSA)............	Según indicaciones del médico.
Vacunas	*Las vacunas se deben aplicar a los adultos si las vacunas de rutina no están al día.*
Td...	Necesitara una dosis de refuerzo cada 10 años.
Gripe..	Una dosis todos los años.
Neumococo...	Una dosis después de los 65 años de edad.
Hepatitis B...	Se recomiendan tres dosis para adultos que están en alto riesgo. Se recomienda también para los viajeros. Pregunte a su médico si es necesaria.
Varicela..	Se puede aplicar si no se lo ha hecho antes, y si la persona no ha tenido Varicela. Se deben aplicar dos dosis separadas por 4 semanas una de otra si usted está en alto riesgo. Pregunte a su médico si es necesaria.
Meningocócica..	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.
Zóster..	Una dosis para adultos que están en alto riesgo. Pregunte a su médico si es necesaria.

Td = tétano y difteria

Staying Healthy Assessment

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
4	Does your baby watch any TV?	No	Yes	Skip	
5	Does your home have a working smoke detector?	Yes	No	Skip	Safety
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

1 –2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you breastfeed your child?	Yes	No	Skip	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
7	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
10	Does your home have a working smoke detector?	Yes	No	Skip	Safety
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
12	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
14	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

#	Question				
15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	

16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

#	Question				
19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Sexual Issues	☐	☐	☐	☐	

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

#	Question				*Clinic Use Only:*
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

#	Question				Category
21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	
☐ Independent Living	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

KERN FAMILY HEALTH CARE
VFC Immunization Service Codes
Revised 2010-08

CPT Code	MCAL	HFAM	
90633	√	√	Administration fee, Hepatitis A vaccine, pediatric/adolescent (2 dose)
90647	√	√	Administration fee, Hib, PRP-OMP conjugate (3 dose)
90648	√	√	Administration fee, Hib, PRP-T conluoate (4 dose)
90649	√	√	Human Papilloma Virus Vaccine, 9 to 26 years of age
90650	√	√	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
90655	√	√	Administration fee, Influenza vaccine, split virus, preservative free, for children 6-35 months of age
90656	√	√	Influenza Virus Vaccine, preservative free 3 years of age and older
90657	√	√	Administration fee, Influenza vaccine 6-35 months of age
90658	√	√	Administration fee, Influenza vaccine 3 years of age and above
90660	√	√	Influenza Virus Vaccine, Live, for intranasal use, 2 through 18 years of age
90669	√	√	Administration fee, Prevnar vaccine
90680	√	√	Rotavirus Vaccine, oral.
90681	√	√	Rotavirus Vaccine, oral (2 dose schedule)
90696	√	√	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTap-IPV)
90698	√	√	Diptheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib.IPV) for intramuscular use, 6 months to 4 years of age
90700	√	√	Administration fee, DTaP vaccine
90707	√	√	Administration fee, MMR vaccine
90710	√	√	Measles, Mumps, Rubella and Varicella Vaccine (MMRV), Live
90713	√	√	Administration fee, inactivated polio vaccine IPV
90714	√	√	Tetanus and Diptheria Toxoids (Td) Tetanus and Diptheria Toxoids (Td) 7 years or older
90715	√	√	Tetanus, Diptheria Toxoids (Td) and Accelluar Pertussis Vaccine, 7 years or older
90716	√	√	Administration fee, Varicella vaccine
90723	√	√	Administration fee, DTap-HepB-IPV
90734	√	√	Meningococcal Vaccine, Conjugate, Menactra

CPT Code	MCAL	HFAM	
90743	√	√	Administration fee, hepatitis B vaccine, adolescent (2 dose)
90744	√	√	Administration fee, hepatitis B vaccine pediatric/adolescent (3 dose)
90748	√	√	COMVAX Vaccine Haemophilus Influenza (Pedvax HIB)