



12 - Month Child Health Supervision (EPSDT) Visit

NAME: _____ DOB: _____ DOV: _____ AGE: _____ SEX: _____ MED REC#: _____

HT: _____ (____%)	Temp: _____	Pulse: _____	Meds: _____
WT: _____ (____%)	Pulse Ox-Optional: _____		
HC: _____ (____%)	Resp: _____		
	Allergies: _____	<input type="checkbox"/> NKDA	
	Reaction: _____		

HISTORY:

Parent Concerns:

Initial/Interval History:

FSH: FSH form reviewed (check other topics discussed):

Daily care provided by Daycare Parent

Other: _____

Adequate support system? Yes No _____

Adequate respite? Yes No _____

SENSORY SCREENING:

Any parent concerns about vision or hearing? Yes No

Vision:

Follows objects and eyes team together: Yes No

Hearing:

Responds to sounds: Yes No

DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:

Parent Concerns Discussed? (Required) Yes

Standardized Screen Used? (Suggested by AAP) Yes No

See instrument form: PEDS Ages & Stages

Other: _____

DB Concerns: (e.g. sleep/feeding) _____

PHYSICAL EXAMINATION (check appropriate box):

	NL	AB	NE	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanels				
Eyes: Red Reflex, Appearance				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia/ Femoral Pulses				
Extremities, Clavicles, Hips				
Muscular				
Neuromotor				
Back/Sacral Dimple				

Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)			
Walks independently (or with minimal help)	Y	N	
Cruises (walks holding on to furniture/hands/etc.)	Y	N	
Fine Motor Skills			
Mature overhand pincer	Y	N	
Secures small wad of paper	Y	N	
Makes mark with crayon	Y	N	
Feeds self crackers	Y	N	
Language/Socioemotional/Cognitive Skills			
Says "Dada" or "Mama" (appropriately; 10 mos)	Y	N	
Says one word other than "Mama/Dada" (11m)	Y	N	
Understands "No" (10m)	Y	N	
Understands one step command w/gesture	Y	N	
Uncovers hidden object	Y	N	
Waves (red flag)	Y	N	
Points (red flag)	Y	N	
Plays peek-a-boo (red flag)	Y	N	
Parent – Infant Interaction			
Interaction appears age appropriate	Y	N	

Clinician concerns regarding interaction: _____

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ANTICIPATORY GUIDANCE:

Select at least one topic in each category (as appropriate to family):

Injury/Serious Illness Prevention:

- Car Seat Falls No strings around neck No shaking
- Burns-hot water heater max temp 125 degrees F Smoke alarms
- No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW) Sun protection Walkers Hanging cords
- Fever management Other: _____

Violence Prevention:

- Adequate support system? Adequate respite? Feel safe in neighborhood?
- Domestic Violence? No Shaking Gun Safety
- Other: _____

Sleep Safety Counseling:

- Sleep Safety Read to infant (eg. Reach out and Read)
- Other: _____

Nutrition Counseling:

- Breast Formula Weaning to cup Whole cow's milk okay after 1 yr
- Feeding self solids Vitamins Honey okay after 1 yr
- No popcorn, peanuts, hard candy Finger foods Limit juice (4 oz or less/day) Other: _____

What to anticipate before next visit:

- May want more independence (especially in feeding) Common to feel less confident as a parent when child has mobility and desire for independence
- Okay to allow infant to finger feed Weight gain slows at 12 mos Child proofing Discipline Coping with separation Different rates of development are normal Other: _____

PROCEDURES:

- Hematocrit or Hemoglobin (required once between 9-12 mos)
- Blood lead test (required once between 9-12 mos)
- TB test (if at risk)

DENTAL REMINDER

PCP screen at 1st tooth eruption Fluoride source?

IMMUNIZATIONS DUE at this visit:

Catch-up on vaccines

DTap4 # _____

- Given Not Given Up to Date

Hib4 # _____

- Given Not Given Up to Date

PCV4 # _____

- Given Not Given Up to Date

MMRV1 # _____

- Given Not Given Up to Date

HepA # _____

- Given Not Given Up to Date

Flu (yearly)

- Given Not Given Up to Date

Catch-up vaccines

HepB # _____

- Given Not Given Up to Date

IPV

- Given Not Given Up to Date

Reason Not Given if due: List Vaccine(s) not given:

- Vaccine not available _____
- Child ill _____
- Parent Declined _____
- Other _____

NOTE: See 9 month form if child's mother was HEPBsAg positive

ASSESSMENT: Healthy, no problems

PLAN/RECOMMENDATIONS: Do vaccines/procedures marked above Other _____

Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ **Date:** _____