



(Optional) 1-Week Child Health Supervision (EPSDT) Visit

Patient Sticker

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: _____

Maternal & Birth History: Birth HX form reviewed

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:
 Blinks in reaction to bright light Yes No

Hearing:
 Passed NBHS (B) Yes Not Given U/K Failed NBHS
 Responds to sounds Yes No Left Right

PHYSICAL EXAMINATION (check box)

	N	A	N	COMMENTS
	L	B	E	
General				NL-normal, AB-abnormal, NE-not examined
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				

DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT

Parent Concerns Discussed? (Required) Yes
 Standardized Screen Used? (Optional) Yes No
 See instrument form: PEDS Ages & Stages
 Other _____

DB Concerns: (e.g. crying/colic) _____

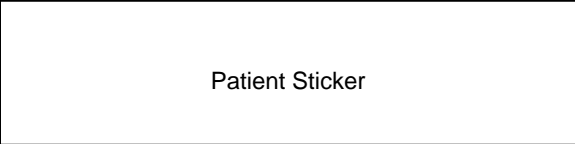
Clinician Observations: (Suggested options)

Motor skills (observe head, trunk and limb control)	Y	N
Visually tracks objects to midline	Y	N
Moves arms and legs equally	Y	N
Arms and legs are usually flexed	Y	N
Full head lag in pull to sit from supine	Y	N
Raises head slightly off table in prone	Y	N
Moro, root, grasp, suck present	Y	N
Face symmetric with cry	Y	N
Fine Motor skills		
Hands are usually fistled	Y	N
Grasps objects reflexively	Y	N
Language/Socioemotional skills		
Vocalizes/Coos	Y	N
Startles at loud noise	Y	N
Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N

Clinician concerns re interaction: _____

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NAME _____ DOB _____
MED RECORD # _____ DOV _____



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 No sun exposure
 Fever management Other _____

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

Sleep Positioning Counseling:
 Sleep (on back) Sleep Safety Normal for newborns to sleep most of the day and night
 Other _____

Nutrition Counseling:
 Breast Formula Solids (4-6mo) 3-4 hour between feeding
 Less frequent stools typical for bottle fed infants 5-8 wet diapers/day
 Vitamins/Fluoride No honey No bottle prop No microwave
 Other _____

What to anticipate before next visit:
 More awake time Sleep cycle gets more regular Change in feeding/stooling patterns
 Other: _____

PROCEDURES:
 Hereditary/Metabolic Screening needed
 Hereditary/Metabolic Screening results reviewed – Normal
 Hereditary/Metabolic Screening results reviewed – Other: _____

IMMUNIZATIONS DUE at this visit:

HepB # _____
 Given Not Given Up to Date

Reason Not Given if due List Vaccine(s) not given:
 Vaccine not available _____
 Child ill _____
 Parent Declined _____
 Other _____

Assessment: Healthy, No problems

Plan/Recommendations: Do vaccines/procedures marked above Anticipatory Guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____

Date: _____