Oklahoma HealthCare Authority

2 - Year Child Health Supervision (EPSDT) Visit

Patient Sticker

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

HT: _____(_____%)
WT: _____(_____%)
HC: _____(_____%)

Temp: _____ Pulse:_____ Meds: _____
Pulse Ox-Optional: _____
Resp: _____
Allergies: _____ ❑ 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 _____

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. sleep/tantrums) _____

_____
_____
_____

Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)		
Still holds onto stairs railings when walking stairs	**Y**	**N**
Walks backward; stoops or squats with confidence	**Y**	**N**
Fine Motor Skills		
Enjoys scribbing	**Y**	**N**
Language/Socioemotional/ Cognitive Skills		
Uses 2-3 word sentences	**Y**	**N**
Imitates parents; enjoys affection and attention	**Y**	**N**
Need time to change activities; destructive if mad	**Y**	**N**
Can't sit still or play with a toy > a few minutes	**Y**	**N**
Shows interest in dressing, brushing hair/teeth	**Y**	**N**
Potty trained (okay if not)	**Y**	**N**
Plays more *alongside* than *with* friends; doesn't cooperate or share well	**Y**	**N**
Parent – Infant Interaction		
Interaction appears age appropriate	**Y**	**N**

Clinician concerns regarding interaction:

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

PHYSICAL EXAMINATION (check appropriate box):

	N L	AB	N E	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				

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NAME: _____ DOB: _____
MED RECORD #: _____ DOV: _____

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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 ❑ 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:
❑ Bedtime interaction ❑ Read to child (e.g. Reach out and Read)
❑ Other: _____

Nutrition Counseling:
❑ Begin 2% cow's milk (~16 oz/day) ❑ Limit juice (4 oz or less/day)
❑ Whole grains ❑ Vitamins ❑ No popcorn, peanuts, hard candy
❑ Other:_____

What to anticipate before next visit:
❑ Child-proofing ❑ Establishes routines ❑ Discipline ❑ Help child learn self-control skills (e.g., not interrupting, not fighting with siblings) ❑ Offer clear and simple choices ❑ Don't expect sharing ❑ Different rates of development are normal ❑ Other:

PROCEDURES:
❑ Hematocrit or Hemoglobin
❑ TB Test
❑ Cholesterol Screening
❑ Blood lead test **(is required at this age)**

DENTAL REMINDER
❑ PCP screen until 3 ❑ Fluoride source?

IMMUNIZATIONS DUE at this visit:
Flu (yearly)
❑ Given ❑ Not Given ❑ Up to Date
Date Flu previously given: _____
Catch-up on vaccines:
HepB #_____
❑ Given ❑ Not Given ❑ Up to Date
DTap #_____
❑ Given ❑ Not Given ❑ Up to Date
Hib #_____
❑ Given ❑ Not Given ❑ Up to Date
IPV #_____
❑ Given ❑ Not Given ❑ Up to Date
PCV #_____
❑ Given ❑ Not Given ❑ Up to Date
MMRV #_____
❑ Given ❑ Not Given ❑ Up to Date
Vaccines for High-Risk:
MPSV4 (Meningococcal)
❑ 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:** _____