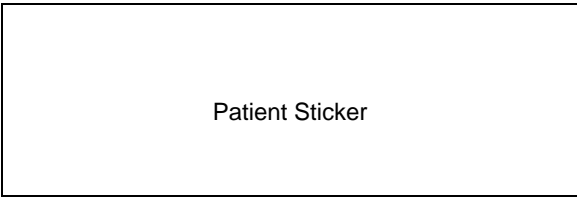




3-Year Child Health Supervision (EPSDT) Visit



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

HT _____ (_____ %)	Temp _____	Pulse _____	Meds: _____
WT _____	Pulse Ox-Optional _____		
BP _____ (_____ %)	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 _____

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/feeding) _____

Clinician Observations/History: (Suggested options)

Motor skills		
Hops on one foot; walks in a line	Y	N
Fine Motor skills		
Needs no help with eating; can use knife to butter	Y	N
Can brush teeth, wash hands, get a drink	Y	N
Language/Socioemotional/Cognitive skills		
Uses 3-5 word sentences; uses plurals (cats/dogs)	Y	N
Asks who, what, where and when questions	Y	N
Understands "now," "soon," & "later"	Y	N
3-minute attention span; minimal understanding of yesterday and tomorrow	Y	N
Identifies some colors; draws easy shapes	Y	N
Uses bathroom with some help	Y	N
Can almost dress self	Y	N
Likes to be with other children but still doesn't cooperate or share well	Y	N
Parent – Child Interaction		
Interaction appears age appropriate	Y	N
Clinician concerns re interaction: _____		

SENSORY SCREENING:
Any parent concerns about vision or hearing? Yes No
Vision: (at least 1 acuity/alignment exam required between 3 and 5yrs)
 Acuity (Allen cards, Snellen chart or HOTV test) done Yes No
Hearing:
 Passed Screen Right Left Bilaterally
 Failed screen Right Left Bilaterally
 referred for Audiology evaluation Conditioned play audiometry or
 Acoustic emittance testing (including reflexes) or OAEs

PHYSICAL EXAMINATION (check appropriate box)

	N L	A B	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Eyes: Red Reflex, Appearance, Light reflex symmetric				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia				
Extremities				
Muscular				
Neuromotor				
Back				

(EPSDT) 3-Year Visit Page 2

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 Burns-hot water heater max temp 125 degrees F
- Smoke alarms No passive smoke Sun protection Water safety
- Other _____

Violence Prevention:

- Adequate support system? Adequate respite? Feel safe in neighborhood?
- Domestic Violence? Gun Safety
- Other _____

Sleep Counseling/Interaction :

- Sleep Interaction Read to child (e.g. Reach out and Read)
- Limit TV (day and nighttime)
- Other _____

Nutrition Counseling:

- Begin 2% cow's milk (~16 oz/day) Limit juice (4 oz or less/day)
- Whole grains Healthy snacks Vitamins No Popcorn, peanuts, hard candy
- Other _____

What to anticipate before next visit:

- Child-proofing Discipline Helping child learn self-control skills (e.g.-not interrupting, not fighting with sibs)
- Different rates of development are normal Establish routines Offer simple choices
- Other:

PROCEDURES: (if at risk or not previously tested)

- Hematocrit or Hemoglobin
- TB Test
- Blood Lead Test
- Cholesterol Screening

DENTAL REMINDER:

- Yearly dental referral Fluoride source?

IMMUNIZATIONS DUE at this visit:

Flu (yearly) Given Not Given Up to Date
 Date Flu previously given _____

Catch-up vaccines

_____ # _____
 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 listed above Other _____
 See box above for Anticipatory Guidance Topics discussed at today's visit

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____

Date: _____