



# By 1 - Month 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: \_\_\_\_\_  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 \_\_\_\_\_

**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/History: (Suggested options)**

<b>Motor skills</b> (observe head, trunk and limb control)		
Visually tracks objects horizontally and vertically	Y	N
Moves arms and legs equally	Y	N
Arms and legs are not always flexed	Y	N
Partial head lag in pull to sit from supine	Y	N
Raises chest off table in prone	Y	N
<b>Fine Motor skills</b>		
Hands are often unfisted	Y	N
Still grasps objects reflexively	Y	N
<b>Language/Socioemotional skills</b>		
Vocalizes/Coos	Y	N
Smiles at seeing parents' face	Y	N
Startles at loud noise	Y	N
Turns head toward direction of sound	Y	N
<b>Parent – Infant Interaction</b> (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N

Clinician concerns re interaction:

**SENSORY SCREENING:**  
**Any parent concerns about vision or hearing?**  Yes  No

**Vision:**  
 Blinks in reaction to bright light  Yes  No  
 Blinks in reaction to visual threat  Yes  No (normal by 3m)

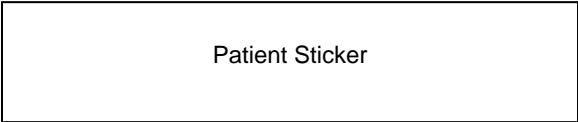
**Hearing:**  
 Passed NBHS (B)  Yes  Not Given  U/K  Failed NBHS  
 Responds to sounds  Yes  No  Left  Right

**PHYSICAL EXAMINATION (check appropriate box)**

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



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

**Nutrition Counseling:**  
 Breast  Formula  Solids (4-6mos)  3-4 hour between feeding  
 Less frequent stools typical for bottle fed infants  5-8 wet diapers/day  
 Vitamins  No honey  No bottle prop  No microwave  
 No infant feeders  Other \_\_\_\_\_

**What to anticipate before next visit:**  
 Sleep cycle gets more regular  Change in feeding/stooling patterns  
 Rolling over by 4 mos  Okay to add cereal at 4 mos  Back to work?  
 Weaning?  Temperament may become more evident  
 Other:

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

**DENTAL REMINDER**  
PCP screen at 1<sup>st</sup> tooth eruption

**IMMUNIZATIONS DUE at this visit:**

**HepB1 (if needed) #** \_\_\_\_\_  
 Given  Not Given  Up to Date

<b>Reason Not Given if due</b>	<b>List Vaccine(s) not given:</b>
<input type="checkbox"/> Vaccine not available	_____
<input type="checkbox"/> Child ill	_____
<input type="checkbox"/> Parent Declined	_____
<input type="checkbox"/> Other _____	_____

**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:** \_\_\_\_\_