



(Optional) 15- 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: _____

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 (observe head, trunk and limb control)		
Walks independently	Y	N
Creeps/Crawls up stairs	Y	N
Fine Motor skills		
Feed self, drinks from cup	Y	N
Scribbles spontaneously	Y	N
Language/Socioemotional/Cognitive skills		
Says 3-6 words	Y	N
Understands simple commands	Y	N
Listens to a story	Y	N
Points to one or more body parts	Y	N
Cooperates while dressing	Y	N
Waves (red flag)	Y	N
Points (red flag)	Y	N
Plays Peek-a-boo (red flag)	Y	N
Parent – Infant Interaction		
Appears age appropriate	Y	N

Clinician concerns re 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	A B	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanels				
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/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 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 Counseling/Interaction :
 Sleep Safety Read to infant (e.g. Reach out and Read)
 Other _____

Nutrition Counseling:
 Breast Whole cow's milk until 2yrs Feeding self solids/finger foods
 Vitamins No Popcorn, peanuts, hard candy Limit juice (4 oz or less/day)
 Other _____

What to anticipate before next visit:
 May want more independence (especially in feeding) Variable appetite
 Okay to allow infant to finger feed Child-proofing
 Discipline Different rates of development are normal Other:

PROCEDURES:
 Blood Lead Test (if not previously tested)
 TB Test (if at risk)

DENTAL REMINDER:
 PCP screen at 1st tooth eruption Fluoride source?

IMMUNIZATIONS DUE at this visit :

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

Catch-up vaccines

Hep B # _____
 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

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

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ **Date:** _____