



18-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: _____	<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 (observe head, trunk and limb control)		
Walks up stairs	Y	N
Fine Motor skills		
Uses spoon	Y	N
Scribbles spontaneously	Y	N
Language/Socioemotional/Cognitive skills		
Mature jargoning (mumbles w/ inflection)	Y	N
Understands 1-step command w/o gesture (16mo)	Y	N
Points to one or more body parts	Y	N
Cooperates while dressing	Y	N
Likes to be with other children	Y	N
Pretend play	Y	N
Waves (red flag)	Y	N
Points (red flag)	Y	N
Parent – Infant Interaction		
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, Hips				
Muscular				
Neuromotor				
Back/Sacral dimple				

(EPSDT) 18-Month 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 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:

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

What to anticipate before next visit:

- May want more independence (especially in feeding) Variable appetite Child-proofing Discipline Help child learn self-control skills (e.g.-not interrupting, not fighting with sibs) Different rates of development are normal Establish routines Offer simple choices
- For a sense of security provide familiar objects for comfort Other:

PROCEDURES: (if at risk or not previously tested)

- Hematocrit or Hemoglobin
- TB Test
- Blood Lead Test

DENTAL REMINDER:

- PCP screen until 3 Fluoride source?

IMMUNIZATIONS DUE at this visit:

- HepA2** # _____
 Given Not Given Up to Date
- Flu (yearly)**
 Given Not Given Up to Date
Date Flu previously given _____

Catch-up 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

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: _____