Oklahoma HealthCare Authority

# 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)**

| **Motor skills** (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** |
| **Fine Motor skills** | | |
| Hands are often unfisted | **Y** | **N** |
| Still grasps objects reflexively | **Y** | **N** |
| **Language/Socioemotional skills** | | |
| 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** |
| **Parent – Infant Interaction** (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

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

**PHYSICAL EXAMINATION (check 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 | | | | |

# (EPSDT) 1- Month Visit Page 2

NAME: _____ DOB: _____

MED RECORD #: _____

Patient Sticker

**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 (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW) ❑ 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 (4-6mo) ❑ 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 1st tooth eruption

**IMMUNIZATIONS DUE at this visit:**

**HepB1 (if needed) #_____**

❑ 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 marked above ❑ Other** _____
**❑ Anticipatory guidance discussed (as described in box above)**

_____
_____
_____
_____
_____
_____
_____
_____
_____

**Next Health Supervision (EPSDT) Visit Due:** _____

**Provider Signature:**_____ **Date:** _____