



## By 1- Month Child Health Supervision (EPSDT) Visit

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
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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				

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NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
MED RECORD #: \_\_\_\_\_



**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 1<sup>st</sup> tooth eruption

**IMMUNIZATIONS DUE at this visit:**

**HepBI (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

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**Plan/Recommendations:**  Do vaccines/procedures marked above  Other \_\_\_\_\_  
 Anticipatory guidance discussed (as described in box above)

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**Next Health Supervision (EPSDT) Visit Due:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_

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