Oklahoma HealthCare Authority

4 - 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 beyond midline	**Y**	**N**
Moves arms and legs equally	**Y**	**N**
Rolls over stomach to back	**Y**	**N**
Supports on wrists in prone	**Y**	**N**
ATNR (fencer position) no longer obligate	**Y**	**N**
Sits with support	**Y**	**N**
Fine Motor skills		
Hands are unfisted	**Y**	**N**
Manipulates fingers	**Y**	**N**
Language/Socioemotional Skills		
Vocalizes/Coos	**Y**	**N**
Orients to voice	**Y**	**N**
Laughs out loud	**Y**	**N**
Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	**Y**	**N**

Clinical concerns regarding 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 3 mos)

Hearing:
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 #: _____ DOV: _____

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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 ❑ Gun Safety
❑ Other: _____

Sleep Safety Counseling:
❑ Sleep (on back) ❑ Sleep Safety
❑ 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
❑ Sitting alone by 6 mos ❑ Okay to add solids at 6 mos ❑ Back to work?
❑ Weaning? ❑ Temperment style ❑ Different rates of development are normal ❑ Other:

PROCEDURES:

DENTAL REMINDER
PCP screen 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

HepB2 (if needed) #_____
❑ Given ❑ Not Given ❑ Up to Date

DTap2 #_____
❑ Given ❑ Not Given ❑ Up to Date

Hib2 # _____
❑ Given ❑ Not Given ❑ Up to Date

IPV2 #_____
❑ Given ❑ Not Given ❑ Up to Date

PCV2 #_____
❑ Given ❑ Not Given ❑ Up to Date

Rotavirus2 #_____
❑ 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:** _____