



## 9 - 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 \_\_\_\_\_

**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 box):**

**DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:**  
 Parent Concerns Discussed? **(Required)**  Yes  
 Standardized Screen Used? (Suggested by AAP)  Yes  No  
 See instrument form:  PEDS  Ages & Stages  
 Other: \_\_\_\_\_  
**DB Concerns:** (e.g. sleep/feeding) \_\_\_\_\_  
 \_\_\_\_\_

**Clinician Observations/History: (Suggested options)**

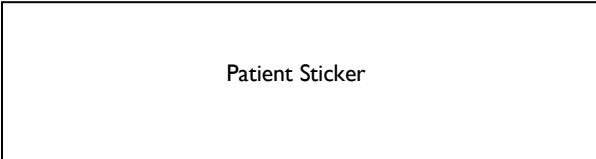
<b>Motor Skills</b> (observe head, trunk, and limb control)		
Pulls up to stand	Y	N
Cruises (walks holding on to furniture/ hand/ etc.)	Y	N
<b>Fine Motor Skills</b>		
Three finger grasp	Y	N
Secures small wad of paper	Y	N
Bangs objects together	Y	N
Feeds self crackers	Y	N
<b>Language/Socioemotional/Cognitive Skills</b>		
Says "Dada" or "Mama" (non-specifically)	Y	N
Looks over edge for dropped object (object permanence)	Y	N
Stranger anxiety	Y	N
Waves <b>(red flag)</b>		
Points <b>(red flag)</b>		
Plays peek-a-boo <b>(red flag)</b>		
<b>Parent - Infant Interaction</b>		
Interaction appears age appropriate	Y	N

Clinician concerns regarding interaction: \_\_\_\_\_

	N L	AB	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanel				
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: \_\_\_\_\_



### 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)  Walkers  Hanging cords  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 Safety  Read to infant (eg Reach out and Read)
- Other: \_\_\_\_\_

#### Nutrition Counseling:

- Breast  Formula  Solids  Less frequent stools typical for bottle fed infants
- 5-8 wet diapers/day  Vitamins  No honey  No microwave
- No infant feeders  Other: \_\_\_\_\_

#### What to anticipate before next visit:

- May want more independence (especially in feeding)  May be walking by 12 mos
- Okay to allow infant to finger feed  Back to work?
- Weaning?  Temperament style  Walkers  Child-proofing
- Discipline  Different rates of development are normal  Other: \_\_\_\_\_

### PROCEDURES:

- Hematocrit or Hemoglobin (required between 9-12 mos)
- Blood lead test (required once between 9-12 mos)
- TB test (if at risk)

### DENTAL REMINDER

PCP screen at 1<sup>st</sup> tooth eruption  
Fluoride source?

### IMMUNIZATIONS DUE at this visit:

#### Catch-up on 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

#### Reason Not Given if due: List Vaccine(s) not given:

- Vaccine not available \_\_\_\_\_
- Child ill \_\_\_\_\_
- Parent Declined \_\_\_\_\_
- Other \_\_\_\_\_

**NOTE:** Check immunization status according to ACIP schedule (infants born to HBsAg positive mothers should be tested for HVsAG and antibody to HBsAG after completion of the HepB series, at age 9 through 18 months; generally at the next well child visit after completion of the vaccine series).

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