



15 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:

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

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) _____

PHYSICAL EXAMINATION (check appropriate 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				

Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)			
Walks independently	Y	N	
Creeps/crawls up stairs	Y	N	
Fine Motor Skills			
Feed self, drinks from cup	Y	N	
Scribbles spontaneously	Y	N	
Language/Socioemotional/Cognitive Skills			
Says 3-6 words	Y	N	
Understands simple commands	Y	N	
Listens to a story	Y	N	
Points to one or more body parts	Y	N	
Cooperates while dressing	Y	N	
Waves (red flag)	Y	N	
Points (red flag)	Y	N	
Plays peek-a-boo (red flag)	Y	N	
Parent – Infant Interaction			
Interaction appears age appropriate	Y	N	

Clinician concerns regarding interaction: _____

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MED RECORD #: _____ DOV: _____



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) 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 Safety Counseling:

- Sleep Safety Read to infant (eg. Reach out and Read)
- Other: _____

Nutrition Counseling:

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

What to anticipate before next visit:

- May want more independence (especially in feeding) Variable appetite Okay to allow infant to finger feed Child-proofing Discipline
- Different rates of development are normal Other: _____

PROCEDURES:

- Blood lead test (if not previously tested)
- TB test (if at risk)

DENTAL REMINDER

PCP screen at 1st tooth eruption Fluoride source?

IMMUNIZATIONS DUE at this visit:

Flu (yearly)

- Given Not Given Up to Date

Catch-up on vaccines

Hep B # _____

- 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

Hep A # _____

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

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ Date: _____