

30 - 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				

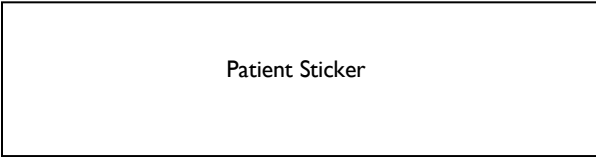
Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)	Y	N
Walks up stairs		
Fine Motor Skills		
Uses spoon		
Scribbles spontaneously		
Language/Socioemotional/Cognitive Skills		
Mature jargoning (mumbles with inflection)		
Understands 1-step command without gesture (16mos)		
Points to one or more body parts		
Cooperates while dressing		
Likes to be with other children		
Pretend play		
Waves (red flag)		
Points (red flag)		
Plays peek-a-boo (red flag)		
Parent - Infant Interaction		
Interaction appears age appropriate		

Clinician concerns regarding interaction: _____

(EPSDT) 30- Month Visit Page 2

NAME: _____ DOB: _____
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:

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

What to anticipate before next visit:

- May want more independence (especially in feeding) Variable appetite
- Child-proofing Discipline Help child learn self-control skills (e.g., not interrupting, not fighting with siblings)
- Different rates of development are normal Establish routines Offer simple choices
- For a sense of security, provide familiar objects for comfort Other: _____

PROCEDURES:

- Hematocrit of Hemoglobin
- TB test
- Blood lead test

DENTAL REMINDER

- PCP screen until 3 Fluoride source?

IMMUNIZATIONS DUE at this visit:

HepA2 # _____

- Given Not Given Up to Date

Flu (yearly)

- Given Not Given Up to Date

Date Flu previously given: _____

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

MMRV # _____

- 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: _____