



3 - Year 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: (at least 1 acuity/alignment exam required between 3 and 5 yrs)
 Acuity (Allen cards, Snellen chart, or HOTV test) done Yes No
Hearing:
 Passed Screen Right Left Bilaterally
 Failed Screen Right Left Bilaterally
 Referred for: Audiological evaluations Conditioned play audiometry or
 Acoustic emittance testing (including reflexes) or OAEs

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 | | | | |
| 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 | | | | |

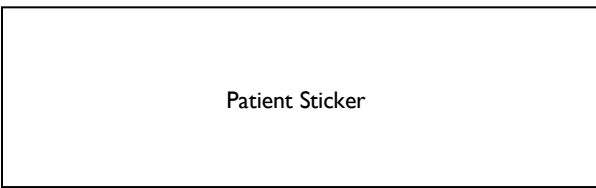
Clinician Observations/History: (Suggested options)

| Motor Skills (observe head, trunk, and limb control) | |
|---|-----|
| Hops on one foot; walks in a line | Y N |
| Fine Motor Skills | |
| Needs no help with eating; can use knife to butter | Y N |
| Can brush teeth, wash hands, get a drink | Y N |
| Language/Socioemotional/Cognitive Skills | |
| Uses 3-5 word sentences; uses plurals (cats/dogs) | Y N |
| Asks "who", "what", "where", and "when" questions | Y N |
| Understands "now", "soon", and "later" | Y N |
| 3-minute attention span; minimal understanding of yesterday and tomorrow | Y N |
| Identifies some colors; draws easy shapes | Y N |
| Uses bathroom with some help | Y N |
| Can almost dress himself | Y N |
| Likes to be with other children but still doesn't cooperate or share well | Y N |
| Parent - Infant Interaction | |
| Interaction appears age appropriate | Y N |

Clinician concerns regarding interaction: _____

(EPSDT) 3 - Year 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 Burns-hot water heater max temp 125 degrees F
- Smoke alarms No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW) Sun protection Water safety
- Other: _____

Violence Prevention:

- Adequate support system? Adequate respite? Feel safe in neighborhood? Domestic Violence? Gun Safety
- Other: _____

Sleep Safety Counseling:

- Sleep Interaction Read to child (eg. Reach out and Read) Limit TV (day and nighttime)
- Other: _____

Nutrition Counseling:

- Begin 2% cow's milk (~16 oz/day) Limit juice (4 oz or less/day)
- Whole grains Healthy snacks Vitamins No popcorn, peanuts, hard candy
- Other: _____

What to anticipate before next visit:

- Child-proofing Discipline Help child learn self-control skills (eg., not interrupting, not fighting with siblings) Different rates of development are normal Establishes routines Offer clear and simple choices Other: _____

PROCEDURES:

- Hematocrit of Hemoglobin
- TB Test
- Cholesterol Screening
- Blood lead test

DENTAL REMINDER

- Yearly dental referral Fluoride source?

IMMUNIZATIONS DUE at this visit:

Flu (yearly)

- Given Not Given Up to Date
- Date Flu previously given: _____

Catch-up on vaccines:

- _____ # _____
- 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 _____
 See box above for Anticipatory Guidance Topics discussed at today's visit

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ Date: _____