Oklahoma HealthCare Authority

5 - Year Child Health Supervision (EPSDT) Visit

Patient Sticker

NAME:_____ DOB:_____ DOV:_____ AGE:_____ SEX:_____ MED REC#: _____

HT: _____(_____%)
WT: _____(_____%)
HC: _____(_____%)

Temp: _____ Pulse:_____ Meds: _____
Pulse Ox-Optional: _____
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 _____

DEVELOPMENTAL/BEHAVIORAL SURVEILLANCE:

(For care management services for SoonerCare members with mental health care needs, contact: OHCA Behavioral Health Services at (800) 652-2010)

Parent Concerns Discussed? **(Required)** ❑ Yes
Standardized Screen Used? (Optional) ❑Yes ❑No
See instrument form: ❑ PEDS ❑ Ages & Stages (0-5 yrs)
❑ Other: _____
DB Concerns: (e.g. behavior/sleep/school) _____

_____

Clinician Observations/History: (Suggested options)

Motor Skills		
Hops on 1 foot; summersaults; catch bounced ball	**Y**	**N**
Fine Motor Skills		
Can use scissors, markers, pencils, clay	**Y**	**N**
Can brush teeth, wash hands, get a drink	**Y**	**N**
Language/Socioemotional Skills		
Can follow 3-step command	**Y**	**N**
Uses complex sentences; knows age, name, town	**Y**	**N**
Has 15-20 minute attention span in a group	**Y**	**N**
Toilet trained (occasional nighttime wetting ok)	**Y**	**N**
Can dress and undress independently	**Y**	**N**
Learning to tie shoes, zippers, and buttons	**Y**	**N**
Likes to be with other children, able to cooperate and share well but doesn't always wants to	**Y**	**N**
Doing well at school with peers and learning	**Y**	**N**
Less confusion between reality and fantasy	**Y**	**N**
Parent – Infant Interaction		
Interaction appears age appropriate	**Y**	**N**

Clinician concerns regarding interaction:

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: (objective testing required if not completed at 4 yrs or at school)
Passed Screen ❑ Right ❑ Left ❑ Bilaterally
Failed Screen ❑ Right ❑ Left ❑ Bilaterally
Refered for: Audiological evaluations ❑ Conditioned play audiometry
❑ Acoustic emittance testing (including reflexes) or ❑ OAEs

PHYSICAL EXAMINATION (check appropriate box):

	NL	AB	NE	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:
❑ Booster car seat until 80 lbs/Seat belts ❑ Smoke alarms ❑ No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
❑ Sun protection ❑ Water safety ❑ Bicycle helmet ❑ Playground safety
❑ Other: _____

Violence Prevention:
❑ Adequate support system? ❑ Adequate respite? ❑ Feel safe in neighborhood? ❑ Domestic Violence? ❑ Gun Safety ❑ Stranger safety
❑ Other: _____

Sleep Safety Counseling:
❑ Bedtime Interaction ❑ May not need naps ❑ Managing out of bed behavior with bedtime pass ❑ Read to child (e.g. Reach out and Read) ❑ Limit TV (day and nighttime)
❑ Other: _____

Nutrition Counseling:
❑ Begin 2% cow's milk (~16 oz/day) ❑ Limit juice/soft drinks (4 oz or less/day)
❑ Whole grains ❑ Healthy snacks ❑ Vitamins
❑ Other: _____

What to anticipate before next visit:
❑ Discipline ❑ Help child learn self-control skills (e.g., not interrupting, not fighting with siblings) ❑ Define unacceptable behavior; introduce a few clear rules (e.g., wash hands before eating) ❑ Other:

PROCEDURES:
❑ 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:
DTap5 #_____
❑ Given ❑ Not Given ❑ Up to Date
IPV4 #_____
❑ Given ❑ Not Given ❑ Up to Date
MMRV2#_____
❑ Given ❑ Not Given ❑ Up to Date
HepA #_____
❑ Given ❑ Not Given ❑ Up to Date
HepB #_____
❑ Given ❑ Not Given ❑ Up to Date

Vaccines for HIGH-RISK:
MPSV4 (Meningococcal)
❑ 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:** _____