Oklahoma HealthCare Authority

11 - 20 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):
Parent Concerns Discussed? **(Required)** ❑ Yes
Standardized Screen Used? (Optional) ❑ Yes ❑ No
See instrument form: ❑ Vanderbilt ADHD
❑ Other _____
DB Concerns: (e.g., behavior/sleep/school) _____

Clinician Observations/History: (HEADSS Suggested)		
Home		
After home school monitoring-who?	**Y**	**N**
Adequate family support system?	**Y**	**N**
Feel safe in neighborhood?	**Y**	**N**
Domestic Violence	**Y**	**N**
Education Grade: School:		
Strengths (e.g., gifited, artistic, athletic, etc.)	**Y**	**N**
Feels connected to school? (e.g., favorite teacher)	**Y**	**N**
Any learning/attention struggles at school?	**Y**	**N**
Grade retention?	**Y**	**N**
Plans for future?	**Y**	**N**
Activities		
Extracurricular/religious activities	**Y**	**N**
Has best friend(s)	**Y**	**N**
Danger/Drugs		
Friends tried or using drugs or alcohol?	**Y**	**N**
Pt tried or using and substances or TOBACCO?	**Y**	**N**
Driving under the influence?	**Y**	**N**
Suicidality/Depression		
Trouble sleeping, irritability, withdrawal?	**Y**	**N**
Suicidal ideation?	**Y**	**N**
Family history of depression?	**Y**	**N**
Any concerns regarding body image?	**Y**	**N**
Sexuality		
Boyfriend or girlfriend?	**Y**	**N**
Has a parent or trusted adult to talk to?	**Y**	**N**
Sexually active?	**Y**	**N**
Birth control?	**Y**	**N**
Parent – Teen Interaction		
Interaction appears age appropriate	**Y**	**N**

Clinician concerns regarding interaction:

SENSORY SCREENING:
Any parent concerns about vision or hearing? ❑ Yes ❑ No
Vision: (one between 11 and 18 yrs)
Acuity (Allen cards, Snellen chart or HOTV test) done ❑ Yes ❑ No
Hearing: (Subjective by history; required if not completed at school)
Passed Screen ❑ Right ❑ Left ❑ Bilaterally
Failed Screen ❑ Right ❑ Left ❑ Bilaterally
Referred for: Audiological evaluations

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: _____

Patient Sticker

ANTICIPATORY GUIDANCE:
Select **at least one** topic in each category (as appropriate to family):

Injury/Serious Illness Prevention:
❑ Seat belts ❑ Drinking and driving ❑ Smoke alarms ❑ No smoking (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
❑ Sun protection ❑ Bicycle helmet
❑ Other: _____

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

Family Interraction/Communication:
❑ Family meetings ❑ Limit TV ❑ Adequate exercise
❑ Other: _____

Nutrition Counseling:
❑ Begin 2% cow's milk (~16 oz/day) ❑ Adequate fruits and vegetables
❑ Whole grains ❑ Healthy snacks ❑ Limit junk food ❑ Vitamins
❑ Other_____

What to anticipate before next visit:
❑ Discipline ❑ Help teen have adequate balance of independence and supervision ❑ Define unacceptable behavior; provide clear rules (e.g., no curfew violations, how to earn privileges) ❑ Family meetings ❑ Other:

PROCEDURES:
❑ Hematocrit or Hemoglobin
❑ Urinalysis
❑ TB Test
❑ Cholesterol Screening
❑ STD Screening
❑ Pelvic Exam

DENTAL REMINDER
❑ Yearly dental referral ❑ Fluoride source?

IMMUNIZATIONS DUE at this visit:

Tdap #_____
❑ Given ❑ Not Given ❑ Up to Date

MCV4 (meningococcal)
❑ Given ❑ Not Given ❑ Up to Date

HPV (papilloma)
❑ Given ❑ Not Given ❑ Up to Date

Flu (yearly)
❑ Given ❑ Not Given ❑ Up to Date
Date Flu previously given: _____

Catch-up vaccines:

MMR #_____
❑ Given ❑ Not Given ❑ Up to Date

IPV #_____
❑ Given ❑ Not Given ❑ Up to Date

Varicella#_____
❑ Given ❑ Not Given ❑ Up to Date

HepA #_____
❑ Given ❑ Not Given ❑ Up to Date

HepB #_____
❑ Given ❑ Not Given ❑ Up to Date

Vaccines for HIGH-RISK:

PPV (pneumonia)
❑ 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:** _____