



24 - 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? (Optional) Yes No
 See instrument form: PEDS Ages & Stages
 Other: _____
DB Concerns: (e.g. sleep/tantrums) _____

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				

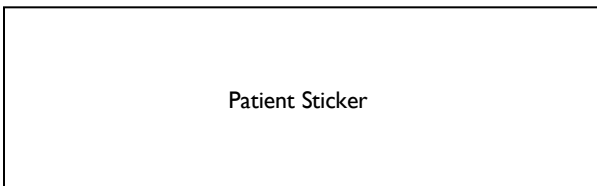
Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)	Y	N
Still holds onto stairs railings when walking stairs	Y	N
Walks backward; stoops or squats with confidence	Y	N
Fine Motor Skills		
Enjoys scribbling	Y	N
Language/Socioemotional/ Cognitive Skills		
Uses 2-3 word sentences	Y	N
Imitates parents; enjoys affection and attention	Y	N
Need time to change activities; destructive if mad	Y	N
Can't sit still or play with a toy > a few minutes	Y	N
Shows interest in dressing, brushing hair/teeth	Y	N
Potty trained (okay if not)	Y	N
Plays more <i>alongside</i> than <i>with</i> friends; doesn't cooperate or share well	Y	N
Parent - Infant Interaction		
Interaction appears age appropriate	Y	N

Clinician concerns regarding interaction: _____

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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 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:

- Bedtime interaction Read to child (eg. Reach out and Read)
- Other: _____

Nutrition Counseling:

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

What to anticipate before next visit:

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

PROCEDURES:

- Hematocrit or Hemoglobin
- TB Test
- Cholesterol Screening
- Blood lead test (is required at this age)

DENTAL REMINDER

- PCP screen until 3 Fluoride source?

IMMUNIZATIONS DUE at this visit:

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

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 _____

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: _____