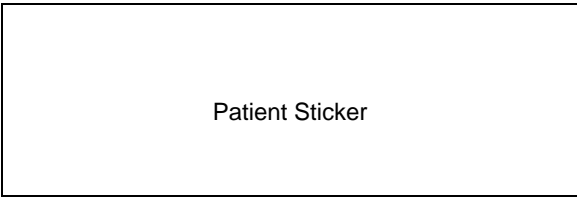




4-Year Child Health Supervision (EPSDT) Visit



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

| | | | |
|-----------------------|-------------------------|-------------------------------|-------------|
| HT _____ (_____ %) | Temp _____ | Pulse _____ | Meds: _____ |
| WT _____ (_____ %) | Pulse Ox-Optional _____ | | |
| BMI _____ (_____ %) | Resp: _____ | | |
| BP _____ | Allergies: _____ | <input type="checkbox"/> 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 5yrs)
 Acuity (Allen cards, Snellen chart or HOTV test) done Yes No
Hearing: (objective testing required at 4 yrs)
 Passed Screen Right Left Bilaterally
 Failed screen Right Left Bilaterally
 referred for Audiology evaluation Conditioned play audiometry or
 Acoustic emittance testing (including reflexes) or OAEs

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. Behavior/sleep) _____

PHYSICAL EXAMINATION (check appropriate box)

| | N L | A B | N E | COMMENTS NL-normal, AB-abnormal, NE-not examined |
|---|--------|--------|--------|---|
| General | | | | |
| Skin | | | | |
| Eyes:Red Reflex, Appearance, Light reflex symmetric | | | | |
| Ears, TMs | | | | |
| Nose | | | | |
| Lips/Palate | | | | |
| Teeth/Gums | | | | |
| Tongue/Pharynx | | | | |
| Neck/Nodes | | | | |
| Chest/Breast | | | | |
| Lungs | | | | |
| Heart | | | | |
| Abd/Umbilicus | | | | |
| Genitalia | | | | |
| Extremities | | | | |
| Muscular | | | | |
| Neuromotor | | | | |
| Back | | | | |

Clinician Observations/History: (Suggested options)

| | |
|---|-----|
| Motor skills | |
| Hop 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/Cognitive 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 want to | Y N |
| Still has confusion between reality and fantasy | Y N |
| Parent - Child Interaction | |
| Interaction appears age appropriate | Y N |

Clinician concerns re interaction: _____

(EPSDT) 4-Year Visit Page 2

NAME _____ DOB _____
MED RECORD # _____



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

Injury/Serious Illness Prevention:
 Booster Car Seat until 80lbs Smoke alarms No passive smoke
 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 Counseling/Interaction :
 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 Helping child learn self-control skills (e.g.-not interrupting, not fighting with sibs)
 Define unacceptable behavior; introduce a few clear rules (e.g. wash hands before eating) Other: _____

PROCEDURES: (if at risk or not previously tested)
 Hematocrit or Hemoglobin
 TB Test
 Blood Lead Test
 Cholesterol Screening

DENTAL REMINDER:
 Yearly dental referral Fluoride source?

IMMUNIZATIONS DUE at this visit:
DTaP5 # _____
 Given Not Given Up to Date
MMRV2 # _____
 Given Not Given Up to Date
IPV4 # _____
 Given Not Given Up to Date
Flu (yearly)
 Given Not Given Up to Date
 Date Flu previously given _____
Catch-up vaccines
HepB # _____
 Given Not Given Up to Date
HepA # _____
 Given Not Given Up to Date
Hib # _____
 Given Not Given Up to Date
PCV # _____
 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 listed above Other _____
 See box above for Anticipatory Guidance Topics discussed at today's visit

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ **Date:** _____