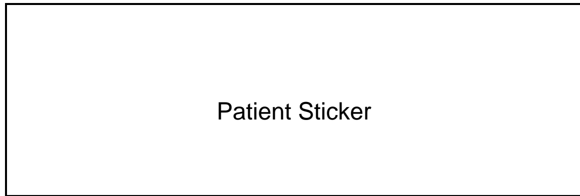
5-Year Child Health Supervision (EPSDT) Visit



NAME____________________DOB _____________ DOV __________AGE _______SEX_____ MED REC#___________

HT __________ (________ %) Temp ____________ Pulse __________________ Meds: ______________________
WT __________ (________ %) Pulse Ox-Optional________________ ______________________
BMI __________ (________ %) Resp: __________________ ______________________
BP __________ **Allergies:** ________________ ❑ 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 ________________
❑ Feel safe in neighborhood? ❑ Yes ❑ No ____________
❑ Domestic Violence? ❑ Yes ❑ No _______________

DEVELOPMENTAL/ BEHAVIORAL SURVEILLANCE
(For care management services for SoonerCare members with mental health care needs contact OHCA Beahvioral Health Services 1.800.652.2010)
Parent Concerns Discussed? (Required) ❑ Yes
Standardized Screen Used? (Optional) ❑ Yes ❑ No
See instrument form: ❑ PEDS (0-8) ❑ Ages & Stages (0-5)
❑ Other____________________
DB Concerns: (e.g. Behavior/Sleep/School) ____________
____
____

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**
Can tie shoes, do 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**
Doing well at school with peers and learning	**Y**	**N**
Less confusion between reality and fantasy	**Y**	**N**
Parent – Child Interaction		
Interaction appears age appropriate	**Y**	**N**

Clinician concerns re interaction:

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

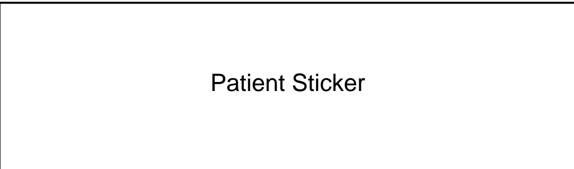
Hearing: (objective testing required if not done at 4 yrs or at school)
Passed Screen ❑ Right ❑ Left ❑ Bilaterally
Failed screen ❑ Right ❑ Left ❑ Bilaterally
referred for ❑ Audiology evaluation ❑Conditioned play audiometry or ❑Acoustic emittance testing (including reflexes) or ❑ OAEs

PHYSICAL EXAMINATION (check appropriate box)

	NL	AB	NE	**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				

(EPSDT) 5-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/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 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)
❑ TB Test
❑ Blood Lead Test
❑ Cholesterol Screening

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 vaccines
DTaP5 #______________
❑ Given ❑ Not Given ❑ Up to Date
MMRV2 #______________
❑ Given ❑ Not Given ❑ Up to Date
IPV4 #______________
❑ Given ❑ Not Given ❑ Up to Date
HepB #______________
❑ Given ❑ Not Given ❑ Up to Date
HepA #______________
❑ Given ❑ Not Given ❑ Up to Date
High-Risk Vaccines
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:** ______________________________