



By 1 - Month Child Health Supervision (EPSDT) Visit

Patient Sticker

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

HT _____ (_____ %) Temp _____ Pulse _____ Meds: _____
 WT _____ (_____ %) Pulse Ox-Optional _____
 HC _____ (_____ %) Resp: _____
 Allergies: _____ NKDA _____
 Reaction: _____

HISTORY:
Parent Concerns: _____

Maternal & Birth History: Birth HX form reviewed
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 ASSESSMENT
Parent Concerns Discussed? (Required) Yes
 Standardized Screen Used? (Optional) Yes No
 See instrument form: PEDS Ages & Stages
 Other _____
DB Concerns: (e.g. crying/colic) _____

SENSORY SCREENING:
Any parent concerns about vision or hearing? Yes No
Vision:
 Blinks in reaction to bright light Yes No
 Blinks in reaction to visual threat Yes No (normal by 3m)
Hearing:
 Passed NBHS (B) Yes Not Given U/K Failed NBHS
 Responds to sounds Yes No Left Right

PHYSICAL EXAMINATION (check appropriate box)

	N L	A B	N E	COMMENTS
	NL-normal, AB-abnormal, NE-not examined			
General				
Skin				
Fontanel				
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				

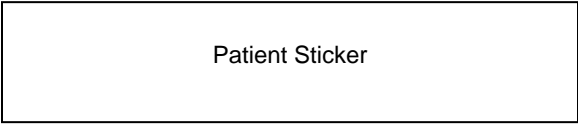
Clinician Observations/History: (Suggested options)

Motor skills (observe head, trunk and limb control)		
Visually tracks objects horizontally and vertically	Y	N
Moves arms and legs equally	Y	N
Arms and legs are not always flexed	Y	N
Partial head lag in pull to sit from supine	Y	N
Raises chest off table in prone	Y	N
Fine Motor skills		
Hands are often unfisted	Y	N
Still grasps objects reflexively	Y	N
Language/Socioemotional skills		
Vocalizes/Coos	Y	N
Smiles at seeing parents' face	Y	N
Startles at loud noise	Y	N
Turns head toward direction of sound	Y	N
Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N

Clinician concerns re interaction: _____

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NAME _____ DOB _____
MED RECORD # _____



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 No sun exposure
 Fever management Other _____

Violence Prevention:
 Adequate support system? Adequate respite? Feel safe in neighborhood?
 Domestic Violence? No Shaking
 Other _____

Sleep Safety Counseling:
 Sleep (on back) Sleep Safety Normal for newborns to sleep most of the day and night
 Other _____

Nutrition Counseling:
 Breast Formula Solids (4-6mos) 3-4 hour between feeding
 Less frequent stools typical for bottle fed infants 5-8 wet diapers/day
 Vitamins No honey No bottle prop No microwave
 No infant feeders Other _____

What to anticipate before next visit:
 Sleep cycle gets more regular Change in feeding/stooling patterns
 Rolling over by 4 mos Okay to add cereal at 4 mos Back to work?
 Weaning? Temperament may become more evident
 Other:

PROCEDURES:
 Hereditary/Metabolic Screening needed
 Hereditary/Metabolic Screening results reviewed – Normal
 Hereditary/Metabolic Screening results reviewed – Other:

DENTAL REMINDER
PCP screen at 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

HepB1 (if needed) # _____
 Given Not Given Up to Date

Reason Not Given if due	List Vaccine(s) not given:
<input type="checkbox"/> Vaccine not available	_____
<input type="checkbox"/> Child ill	_____
<input type="checkbox"/> Parent Declined	_____
<input type="checkbox"/> Other _____	_____

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:** _____