



4-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: _____		<input type="checkbox"/> 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) _____

Clinician Observations/History: (Suggested options)

Motor skills (observe Head, trunk and limb control)		
Visually tracks objects beyond midline	Y	N
Moves arms and legs equally	Y	N
Rolls over stomach to back	Y	N
Supports on wrists in prone	Y	N
ATNR (Fencer position) no longer obligate	Y	N
Sits with support	Y	N
Fine Motor skills		
Hands are unfisted	Y	N
Manipulates fingers	Y	N
Language/Socioemotional skills		
Vocalizes/Coos	Y	N
Orients to voice	Y	N
Laughs out loud	Y	N
Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N
Clinician concerns re interaction: _____		

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:
Responds to sounds Yes No

PHYSICAL EXAMINATION (check appropriate box)

	N L	A B	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, Hips				
Muscular				
Neuromotor				
Back/Sacral dimple				

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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 Gun Safety
- Other _____

Sleep Positioning Counseling:

- Sleep (on back) Sleep Safety
- Other _____

Nutrition Counseling:

- Breast Formula Solids (4-6mo) 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
- Sitting alone by 6 mo Uokay to add solids at 6 months Back to work ?
- Weaning? Temperament style Different rates of development are normal Other:

PROCEDURES:

DENTAL REMINDER

PCP screen at 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

Info provided and consent signed for each one given

HepB2 (if needed) # _____

Given Not Given Up to Date

DTaP2 # _____

Given Not Given Up to Date

Hib2 # _____

Given Not Given Up to Date

IPV2 # _____

Given Not Given Up to Date

PCV2 # _____

Given Not Given Up to Date

Rotavirus2 # _____

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 _____
 Anticipatory Guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ **Date:** _____