



# 6-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. sleep/feeding) \_\_\_\_\_  
 \_\_\_\_\_

**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 both ways	Y	N
ATNR (Fencer position) gone	Y	N
Sits alone	Y	N
Fine Motor skills		
Reaches for and rakes at objects	Y	N
Transfers objects hand to hand (by 5 mo)	Y	N
Regards small wad of paper	Y	N
Language/Socioemotional skills		
Babbles (vowel-consonant)	Y	N
Raspberry noises (by 5 mo)	Y	N
Says Ah-goo (by 5 mo)	Y	N
Parent – Infant Interaction		
Interaction appears age appropriate	Y	N

Clinician concerns re interaction: \_\_\_\_\_

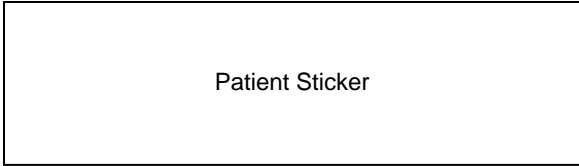
**SENSORY SCREENING:**  
**Any parent concerns about vision or hearing?**  Yes  No  
**Vision:**  
 Follows objects and eyes team together  Yes  No  
**Hearing:**  
 Responds to sounds  Yes  No

**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, Light reflex symmetric				
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				

# (EPSDT) 6-Month 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:**  
 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  Walkers  
 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 Safety  Other \_\_\_\_\_

**Nutrition Counseling:**  
 Breast  Formula  Solids   
 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 may get disturbed when stranger anxiety begins (around 9 mos)  
 Change in feeding/stooling patterns  Pulling up to cruise holding onto furniture by 9 mos  
 Okay to allow infant to finger feed  Back to work?  
 Weaning?  Temperament style  Walkers  
 Child-proofing  Discipline  Different rates of development are normal  
 Other:

**PROCEDURES:**

**DENTAL REMINDER**  
 PCP screen at 1<sup>st</sup> tooth eruption  
 Fluoride (check on type of water and public water supply content)

**IMMUNIZATIONS DUE at this visit:**  
 Info provided and consent signed for each one given

**HepB3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**DTaP3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Hib3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**IPV3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**PCV3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Rotavirus3** # \_\_\_\_\_  
 Given  Not Given  Up to Date

**Flu (yearly)**  
 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:** \_\_\_\_\_