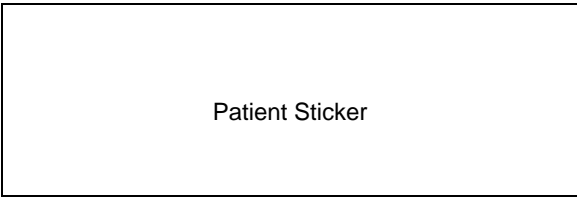




12-Month Child Health Supervision (EPSDT) Visit



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: _____

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:
 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				
Fontanels				
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				

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)		
Walks independently (or with minimal help)	Y	N
Cruises (walks holding on to furniture/hands/etc.)	Y	N
Fine Motor skills		
Mature overhand pincer	Y	N
Secures small wad of paper	Y	N
Makes mark with crayon	Y	N
Feeds self crackers	Y	N
Language/Socioemotional/Cognitive skills		
Says Dada or Mama (appropriately) (10m)	Y	N
Says one word other than Mama/Dada (11m)	Y	N
Understands "NO" (10m)	Y	N
Understands one step command w/ gesture	Y	N
Uncovers hidden object	Y	N
Waves (red flag)	Y	N
Points (red flag)	Y	N
Plays Peek-a-boo (red flag)	Y	N
Parent – Infant Interaction		
Interaction appears age appropriate	Y	N

Clinician concerns re interaction: _____

(EPSDT) 12-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 Sun protection Walkers Hanging cords
 Fever management Other _____

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

Sleep Counseling/Interaction :
 Sleep Safety Read to child (e.g. Reach out and Read)
 Other _____

Nutrition Counseling:
 Breast Formula Weaning to cup Whole cow's milk okay after 1 yr
 Feeding self solids Vitamins Honey okay after 1yr No Popcorn, peanuts, hard candy
 Finger foods Limit juice (4 oz or less/day) Other _____

What to anticipate before next visit:
 May want more independence (especially in feeding) Common to feel less confident as a parent when child has more mobility and desire for independence
 Okay to allow infant to finger feed Weight gain slows at 12 mos Child-proofing Discipline Coping with separation
 Different rates of development are normal Other: _____

PROCEDURES:
 Hematocrit or Hemoglobin
(Required once between 9-12 months)
 Blood Lead Test **(Required once between 9-12 months)**
 TB test (if at risk)

DENTAL REMINDER:
 PCP screen at 1st tooth eruption Fluoride source?

IMMUNIZATIONS DUE at this visit:

DTaP4 # _____
 Given Not Given Up to Date

Hib4 # _____
 Given Not Given Up to Date

PCV4 # _____
 Given Not Given Up to Date

MMRV1 # _____
 Given Not Given Up to Date

HepA # _____
 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

IPV # _____
 Given Not Given Up to Date

Reason Not Given if due **List Vaccine(s) not given:**
 Vaccine not available _____
 Child ill _____
 Parent Declined _____
 Other _____

NOTE: See 9 month form if child's mother was HepBsAg positive

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: _____