



18-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: _____

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				
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 up stairs	Y N
Fine Motor skills	
Uses spoon	Y N
Scribbles spontaneously	Y N
Language/Socioemotional/Cognitive skills	
Mature jargoning (mumbles w/ inflection)	Y N
Understands 1-step command w/o gesture (16mo)	Y N
Points to one or more body parts	Y N
Cooperates while dressing	Y N
Likes to be with other children	Y N
Pretend play	Y N
Waves (red flag)	Y N
Points (red flag)	Y N
Parent – Infant Interaction	
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 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 infant (e.g. Reach out and Read)
 Other _____

Nutrition Counseling:
 Whole cow's milk til 2yrs Limit juice (4 oz or less/day) Feeding self solids/finger foods
 Vitamins No Popcorn, peanuts, hard candy
 Other _____

What to anticipate before next visit:
 May want more independence (especially in feeding) Variable appetite
 Child-proofing Discipline Help child learn self-control skills (e.g.-not interrupting, not fighting with sibs)
 Different rates of development are normal Establish routines Offer simple choices
 For a sense of security provide familiar objects for comfort Other: _____

PROCEDURES: (if at risk or not previously tested)
 Hematocrit or Hemoglobin
 TB Test
 Blood Lead Test

DENTAL REMINDER:
 PCP screen until 3 Fluoride source?

IMMUNIZATIONS DUE at this visit:
HepA2 # _____
 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
DTaP # _____
 Given Not Given Up to Date
Hib # _____
 Given Not Given Up to Date
IPV # _____
 Given Not Given Up to Date
PCV # _____
 Given Not Given Up to Date
MMRV # _____
 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: _____