Oklahoma HealthCare Authority

(Optional) 1-Week 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) _____

_____

Clinician Observations/History: (Suggested options)

Motor skills (observe head, trunk and limb control)		
Visually tracks objects to midline	**Y**	**N**
Moves arms and legs equally	**Y**	**N**
Arms and legs are usually flexed	**Y**	**N**
Full head lag in pull to sit from supine	**Y**	**N**
Raises head slightly off table in prone	**Y**	**N**
Moro, root, grasp, suck present	**Y**	**N**
Face symmetric with cry	**Y**	**N**
Fine Motor skills		
Hands are usually fisted	**Y**	**N**
Grasps objects reflexively	**Y**	**N**
Language/Socioemotional skills		
Vocalizes/Coos	**Y**	**N**
Startles at loud noise	**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

Hearing:
Passed NBHS (B): ❑ Yes ❑ Not Given ❑ U/K ❑ **Failed NBHS**
Responds to sounds: ❑ Yes ❑ No ❑ Left ❑ Right

PHYSICAL EXAMINATION (check box):

	N L	**AB**	**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, Clavicles, Hips				
Muscular				
Neuromotor				
Back/Sacral dimple				

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NAME: _____ DOB: _____
MED RECORD #: _____

Patient Sticker

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 (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW) ❑ No sun exposure ❑ Fever management
❑ Other: _____

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

Sleep Positioning Counseling:
❑ Sleep (on back) ❑ Sleep Safety ❑ Normal for newborns to sleep most of the day and night ❑ 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/Fluoride ❑ No honey ❑ No bottle prop ❑ No microwave
❑ Other: _____

What to anticipate before next visit:
❑ More awake time ❑ Sleep cycle gets more regular ❑ Change in feeding/stooling patterns ❑ Other: _____

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

IMMUNIZATIONS DUE at this visit:

HepB #_____
❑ 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 ❑ Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature:_____ **Date:** _____