

9 - Month Child Health Supervision (EPSDT) Visit

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 _____

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 box):

DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:
 Parent Concerns Discussed? **(Required)** Yes
 Standardized Screen Used? (Suggested by AAP) Yes No
 See instrument form: PEDS Ages & Stages
 Other: _____
DB Concerns: (e.g. sleep/feeding) _____

Clinician Observations/History: (Suggested options)

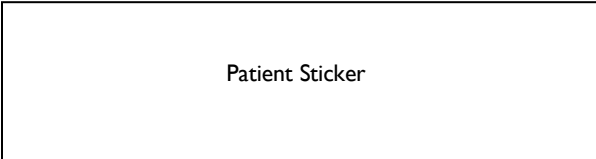
Motor Skills (observe head, trunk, and limb control)	
Pulls up to stand	Y N
Cruises (walks holding on to furniture/ hand/ etc.)	Y N
Fine Motor Skills	
Three finger grasp	Y N
Secures small wad of paper	Y N
Bangs objects together	Y N
Feeds self crackers	Y N
Language/Socioemotional/Cognitive Skills	
Says "Dada" or "Mama" (non-specifically)	Y N
Looks over edge for dropped object (object permanence)	Y N
Stranger anxiety	Y N
Waves (red flag)	
Points (red flag)	
Plays peek-a-boo (red flag)	
Parent – Infant Interaction	
Interaction appears age appropriate	Y N

Clinician concerns regarding interaction: _____

	N L	AB	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanel				
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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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) Walkers Hanging cords 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 Safety Counseling:

- Sleep Safety Read to infant (eg Reach out and Read)
- Other: _____

Nutrition Counseling:

- Breast Formula Solids Less frequent stools typical for bottle fed infants
- 5-8 wet diapers/day Vitamins No honey No microwave
- No infant feeders Other: _____

What to anticipate before next visit:

- May want more independence (especially in feeding) May be walking by 12 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:

- Hematocrit or Hemoglobin (required between 9-12 mos)
- Blood lead test (required once between 9-12 mos)
- TB test (if at risk)

DENTAL REMINDER

PCP screen at 1st tooth eruption

Fluoride source?

IMMUNIZATIONS DUE at this visit:

Catch-up on 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

Reason Not Given if due: List Vaccine(s) not given:

- Vaccine not available _____
- Child ill _____
- Parent Declined _____
- Other _____

NOTE: Check immunization status according to ACIP schedule (infants born to HBsAg positive mothers should be tested for HVsAG and antibody to HBsAG after completion of the HepB series, at age 9 through 18 months; generally at the next well child visit after completion of the vaccine series).

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: _____