



18 - 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

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) _____

PHYSICAL EXAMINATION (check appropriate box):

	NL	AB	NE	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				

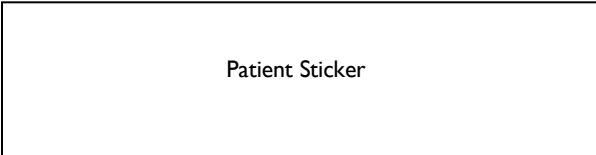
Clinician Observations/History: (Suggested options)

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 with inflection)	Y	N
Understands 1-step command without gesture (16mos)	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
Plays peek-a-boo (red flag)	Y	N
Parent - Infant Interaction		
Interaction appears age appropriate	Y	N

Clinician concerns regarding interaction: _____

(EPSDT) 18 - Month Visit Page 2

NAME: _____ DOB: _____
MED RECORD #: _____ DOV: _____



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) 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 Safety Counseling:

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

Nutrition Counseling:

- Whole cow's milk until 2 yrs 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 siblings)
- Different rates of development are normal Establish routines Offer simple choices
- For a sense of security, provide familiar objects for comfort Other: _____

PROCEDURES:

- Hematocrit of 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 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

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 marked above Other _____

Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ Date: _____