

4 - 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 _____

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 beyond midline	Y	N
Moves arms and legs equally	Y	N
Rolls over stomach to back	Y	N
Supports on wrists in prone	Y	N
ATNR (fencer position) no longer obligate	Y	N
Sits with support	Y	N
Fine Motor skills		
Hands are unfisted	Y	N
Manipulates fingers	Y	N
Language/Socioemotional Skills		
Vocalizes/Coos	Y	N
Orients to voice	Y	N
Laughs out loud	Y	N
Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):		
Interaction appears age appropriate	Y	N

Clinical concerns regarding interaction:

SENSORY SCREENING:

Any parent concerns about vision or hearing? Yes No

Vision:

Blinks in reaction to bright light: Yes No

Blinks in reaction to visual threat: Yes No (normal by 3 mos)

Hearing:

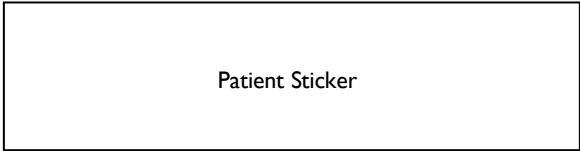
Responds to sounds: Yes No Left Right

PHYSICAL EXAMINATION (check box):

	N	L	AB	N	E	COMMENTS
						NL-normal, AB-abnormal, NE-not examined
General						
Skin						
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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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 Gun Safety
- Other: _____

Sleep Safety Counseling:

- Sleep (on back) Sleep Safety
- 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 No honey No bottle prop No microwave No infant feeders
- Other: _____

What to anticipate before next visit:

- Sleep cycle gets more regular Change in feeding/stooling patterns
- Sitting alone by 6 mos Okay to add solids at 6 mos Back to work?
- Weaning? Temperment style Different rates of development are normal Other: _____

PROCEDURES:

DENTAL REMINDER

PCP screen 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

HepB2 (if needed) # _____
 Given Not Given Up to Date

DTap2 # _____
 Given Not Given Up to Date

Hib2 # _____
 Given Not Given Up to Date

IPV2 # _____
 Given Not Given Up to Date

PCV2 # _____
 Given Not Given Up to Date

Rotavirus2 # _____
 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 Other _____
 Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____

Date: _____