



## 24 - 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:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**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? (Optional)  Yes  No  
 See instrument form:  PEDS  Ages & Stages  
 Other: \_\_\_\_\_  
**DB Concerns:** (e.g. sleep/tantrums) \_\_\_\_\_  
 \_\_\_\_\_

**PHYSICAL EXAMINATION (check appropriate 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				

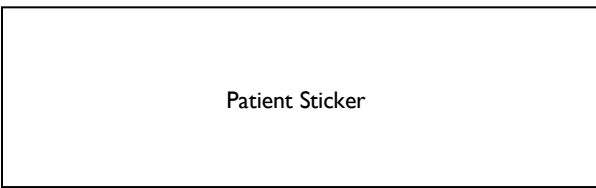
**Clinician Observations/History: (Suggested options)**

Motor Skills (observe head, trunk, and limb control)	Y	N
Still holds onto stairs railings when walking stairs	Y	N
Walks backward; stoops or squats with confidence	Y	N
Fine Motor Skills		
Enjoys scribbling	Y	N
Language/Socioemotional/ Cognitive Skills		
Uses 2-3 word sentences	Y	N
Imitates parents; enjoys affection and attention	Y	N
Need time to change activities; destructive if mad	Y	N
Can't sit still or play with a toy > a few minutes	Y	N
Shows interest in dressing, brushing hair/teeth	Y	N
Potty trained (okay if not)	Y	N
Plays more <i>alongside</i> than <i>with</i> friends; doesn't cooperate or share well	Y	N
Parent - Infant Interaction		
Interaction appears age appropriate	Y	N

Clinician concerns regarding interaction: \_\_\_\_\_

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NAME: \_\_\_\_\_ DOB: \_\_\_\_\_  
MED RECORD #: \_\_\_\_\_ DOV: \_\_\_\_\_



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  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:

- Bedtime interaction  Read to child (eg. Reach out and Read)
- Other: \_\_\_\_\_

#### Nutrition Counseling:

- Begin 2% cow's milk (~16 oz/day)  Limit juice (4 oz or less/day)
- Whole grains  Vitamins  No popcorn, peanuts, hard candy
- Other: \_\_\_\_\_

#### What to anticipate before next visit:

- Child-proofing  Establishes routines  Discipline  Help child learn self-control skills (e.g., not interrupting, not fighting with siblings)
- Offer clear and simple choices  Don't expect sharing  Different rates of development are normal
- Other: \_\_\_\_\_

### PROCEDURES:

- Hematocrit or Hemoglobin
- TB Test
- Cholesterol Screening
- Blood lead test (is required at this age)

### DENTAL REMINDER

- PCP screen until 3  Fluoride source?

### IMMUNIZATIONS DUE at this visit:

#### 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

#### Vaccines for High-Risk:

##### MPSV4 (Meningococcal)

- 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

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**PLAN/RECOMMENDATIONS:**  Do vaccines/procedures marked above  Other \_\_\_\_\_

Anticipatory guidance discussed (as described in box above)

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Next Health Supervision (EPSDT) Visit Due: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_