



2 - 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 horizontally and vertically	Y	N
Moves arms and legs equally	Y	N
Arms and legs are not always flexed	Y	N
Partial head lag in pull to sit from supine	Y	N
Raises chest off table in prone	Y	N
Fine Motor skills		
Hands are often unfisted	Y	N
Still grasps objects reflexively	Y	N
Language/Socioemotional skills		
Vocalizes/Coos	Y	N
Smiles at seeing parents' face	Y	N
Startles at loud noise	Y	N
Turns head toward direction of sound	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
 Blinks in reaction to visual threat: Yes No (normal by 3 mos)

Hearing:

Passed NBHS (B): Yes Not Given U/K Failed
NBHS

Responds to sounds: Yes No Left Right

PHYSICAL EXAMINATION (check box):

	COMMENTS		
	N L	AB	NE
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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MED RECORD #: _____



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 Safety 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 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
- Rolling over by 4 mos Okay to add cereal at 4 mos Back to work?
- Weaning? Temperment may become more evident Other: _____

PROCEDURES:

- Hereditary/Metabolic Screening needed
- Hereditary/Metabolic Screening results reviewed – Normal
- Hereditary/Metabolic Screening results reviewed – Other:

DENTAL REMINDER

PCP screen at 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

HepB2 # _____

- Given Not Given Up to Date

DTap I # _____

- Given Not Given Up to Date

Hib I # _____

- Given Not Given Up to Date

IPVI # _____

- Given Not Given Up to Date

PCVI # _____

- Given Not Given Up to Date

Rotavirus I # _____

- 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: _____