NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: ☐ MALE ☐ FEMALE	PHONE:
DATE OF SERVICE:	INFORMANT:

DISCHARGE TO 5 DAY CHECKUP CHILD HEALTH RECORD

HISTORY

☐ See new patient history form

INTERVAL HISTORY:
☐ NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues, including
Maternal Depression: Y☐ N☐
Findings:

☐ **DEVELOPMENTAL SURVEILLANCE:**
- Gross motor development
- Communication skills/language development
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
☐ Breastmilk
Min per feeding: ____ Number of feedings in last 24 hrs: ____
☐ Formula (type) _____
Oz per feeding: ____ Number of feedings in last 24 hrs: ____
Water source: _____ fluoride: Y ☐ N ☐

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ Hep B

LABORATORY

Initial newborn screening
Completed at birth facility: Y☐ N☐

Deferred: _____
Tests ordered today:

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
Head Circumference: _____ (_____%)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Mouth/throat	☐ Extremities
☐ Head/fontanels	☐ Neck	☐ Back
☐ Skin	☐ Heart/pulses	☐ Musculoskeletal
☐ Eyes	☐ Lungs	☐ Hips
☐ Ears	☐ Abdomen	☐ Neurological
☐ Nose	☐ Genitalia	

Abnormal findings:

Additional:
Subjective Hearing Screening: P☐ F☐
Subjective Vision Screening: P☐ F☐
Newborn Hearing Screening:
☐ ABR ☐ OAE ☐ Unknown
Completion date: ____/____/____ Results:

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:
- Newborn Care
- Parental/Maternal Well-Being
- Newborn Transition
- Safety
- Nutrional Adequacy

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Texas Health Steps

DISCHARGE TO 5 DAY CHECKUP CHILD HEALTH RECORD

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

Discharge to 5 Day Checkup

- Clean mouth with soft cloth twice a day
- No bottle in bed
- Skin, circumcision, umbilical care
- Stooling-color, frequency
- Talk to infant using simple words telling/reading stories
- No bed sharing
- Sleep in crib on back with no loose covers
- 6-8 wet diapers a day
- Adequate weight gain
- Hold to bottle feed, no bottle propping
- How to prepare formula
- Store breast milk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Maintain consistent family routine
- Parents return to work/school
- Postpartum checkup
- Postpartum depression/family stress
- Crib safety with slats ≤2-3/8”
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning
- Keep hand on infant when on bed or changing on table/couch
- No shaking baby (Shaken Baby Syndrome)
- No smoking
- Provide safe/quality day care
- Report domestic violence
- Thermometer use
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds
- Water heater at <120º

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
Ages Birth to 3 months	☐	☐	Gives a startle response to loud, sudden noises within 3 feet
	☐	☐	Calms to a familiar, friendly voice
	☐	☐	Wakes up when you speak or make noise nearby
	☐	☐	Coos and gurgles
	☐	☐	Laughs and uses voice when playing
	☐	☐	Watches your face when spoken to

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:
http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf