9-Month Child Health Supervision (EPSDT) Visit

Patient Sticker

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 ___________________

DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT
Parent Concerns Discussed? (Required) ❑ Yes
Standard Screen Used? **(Suggested by AAP)** ❑ Yes ❑ No
See instrument form: ❑ PEDS ❑ Ages & Stages
❑ Other_____________________
DB Concerns: (e.g. sleep/feeding) ___________________
____
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Clinician Observations/History: (Suggested options)

Motor skills (observe head, trunk and limb control)		
Pulls up to stand	**Y**	**N**
Cruises (walks holding on to furniture/hands/etc.)	**Y**	**N**
Fine Motor skills		
Three finger grasp	**Y**	**N**
Secures small wad of paper	**Y**	**N**
Bangs objects together	**Y**	**N**
Feeds self crackers	**Y**	**N**
Language/Socioemotional/Cognitive skills		
Says Dada or Mama (non-specifically)	**Y**	**N**
Looks over edge for dropped object (object permanence)	**Y**	**N**
Stranger anxiety	**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 re interaction:

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

PHYSICAL EXAMINATION (check appropriate box)

	NL	AB	NE	**COMMENTS** NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanels				
Eyes: Red Reflex, Appearance, Light reflex symmetric				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia/ Femoral Pulses				
Extremities, Hips				
Muscular				
Neuromotor				
Back/Sacral dimple				

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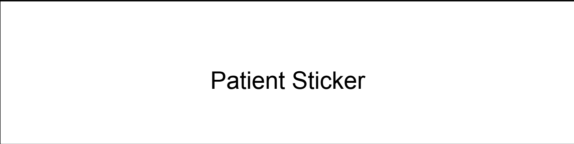
NAME________________________________ DOB _____________
MED RECORD #_______________________ DOV_____________



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 ❑ No sun exposure ❑ 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 Counseling/Interaction :
❑ Sleep Safety ❑ Read to infant (e.g. Reach out and Read)
❑ Other ___________________________

Nutrition Counseling:
❑ Breast ❑ Formula ❑ Solids ❑ Less frequent stools typical for bottle fed infants ❑ 5-8 wet diapers/day ❑ Vitamins ❑ No honey ❑ No microwave ❑ No infant feeders ❑ Other ______________________

What to anticipate before next visit:
❑ May want more independence (especially in feeding) ❑ May be walking by 12 mos ❑ Okay to allow infant to finger feed ❑ Back to work? ❑ Weaning? ❑ Temperament style ❑ Walkers ❑ Child-proofing
❑ Discipline ❑ Different rates of development are normal ❑ Other:

PROCEDURES:
❑ Hematocrit or Hemoglobin
(Required once between 9-12 months)
❑ Blood Lead Test **(Required once between 9-12 months)**
❑ TB test (if at risk)

DENTAL REMINDER:
PCP screen at 1st tooth eruption
Fluoride source?

IMMUNIZATIONS DUE at this visit:
Catch-up 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

Reason Not Given if due	**List Vaccine(s) not given:**
❑ Vaccine not available	______________________
❑ Child ill	______________________
❑ Parent Declined	______________________
❑ Other ____________	______________________

NOTE: Check immunization status according to ACIP schedule (infants born to HBsAg positive mothers should be tested for HVsAg and antibody to HBsAg after completion of the HepB series, at age 9 through 18 months; generally at the next well child visit after completion of the vaccine series).

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:** ______________________________