

**0-9
Months
Visit**

EPSDT
Screening
Date

		/		/			

Medicaid
ID#

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Name _____ Birthdate _____ Historian _____

Age _____ Allergies _____ Medications _____

Weight _____ lbs. _____ oz. Length _____ in. Head circ. _____ cm Temp. _____ P _____ R _____ BP* _____

Delivery Method:

C-Section Vaginal

Complications _____

Birth Weight _____

Gestation _____

Hep B @ Birth Yes ___ No ___

CCHD Screening Results _____

Nutrition

Breast _____ times per day

Formula _____ oz. per day.

Brand _____

With iron? Yes No

Baby food _____ servings/ day

Table foods Yes No

WIC: Yes No

Elimination:

Stool/day _____ Urine/day _____

Sleep Habits:

Normal Abnormal

History Update:

Are there any changes in your family history?

Illnesses since last visit? Yes No

Developmental Surveillance:

Normal Abnormal _____

Developmental Screening:

(Required at 9 months using a standardized tool)

Hearing/Speech:

Responds to sounds Yes No

Imitates speech Yes No

Vision:

Notices small objects Yes No

Lab Procedures:

Newborn Blood Screening*

Lead Screening*

Risk: High Low

BLL result _____ (if required)

TB testing* Result _____

Hgb or Hct* Result _____

Fluoride varnish applied (< age 3): Yes No

Physical Exam (UNCLOTHED) Yes No √ = nl X = abnl

General	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Head	<input type="checkbox"/>	Lungs	<input type="checkbox"/>
Fontanel	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>
Neck	<input type="checkbox"/>	Spine	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Extremities	<input type="checkbox"/>
Red Reflex	<input type="checkbox"/>	Hips	<input type="checkbox"/>
Alignment	<input type="checkbox"/>	Skin	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Neuro	<input type="checkbox"/>
Nose	<input type="checkbox"/>		
Throat/Mouth/Teeth	<input type="checkbox"/>		
Femoral Pulses	<input type="checkbox"/>		
Genitalia			
Female	<input type="checkbox"/>		
Male	<input type="checkbox"/>		
Testes	<input type="checkbox"/>		

Anticipatory Guidance

Safety

Car seat, facing backwards

Smoke detectors in home

Hot water < 120 degrees

Crib safety

Poison Control #

Child proof rooms

Always supervise bath

Lead exposure prevention

Health/Nutrition

Choking prevention

Continue formula or breast milk

Introduce table, finger foods

Introduce cup, weaning

Avoid honey

Oral Health, teething, fluoride varnish

No bottle in bed or bottle propping

Psychosocial/Behavioral Assessment

Develop routines

Sleep, bedtime routine

Opportunities to explore

Talk, Read to baby

Infant bonding

Impression

Well-baby, normal growth and development

Plan/Referrals

Immunization Record on file:

Yes No

Immunizations up to date:

Yes No

Vaccine information given:

Yes No

Handouts _____

Next EPSDT visit _____

MD/NP Signature

*Risk Assessment to be performed with appropriate actions to follow, if positive; otherwise at the standard age according to AAP/Bright Futures CPT only copyright 2010 American Medical Association. All rights reserved.