0-9 Months Visit

EPSDT Screening Date | | | / | | | / | | | Medicaid ID# | | | | | | | | | |

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)

Maternal Depression Screening (1,2,4&6 months)

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_____
□ Anemia testing (Hgb or Hct)*Result_____

Fluoride varnish applied (< age 3): Yes□ No□
*Fluoride Supplementation Yes □ No □

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

General	□	Heart	□
Head	□	Lungs	□
Fontanel	□	Abdomen	□
Neck	□	Spine	□
Eyes	□	Extremities	□
Red Reflex	□	Hips	□
Alignment	□	Skin	□
Ears	□	Neuro	□
Nose	□		
Throat/Mouth/Teeth	□		
Femoral Pulses	□		
Genitalia			
Female	□		
Male	□		
Testes	□		

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*