0-9 Months Visit	EPSDT Screening Date			/			/			Medicaid ID#									

Name_______________________________________Birthdate________________Historian________________________
Age__________Allergies__________________Medications____
Weight____lbs. ____z. Length ____in. Weight for Length____ HC ____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_______
□ Anemia testing (Hgb or Hct)*Result_______

Fluoride varnish applied: 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 Recommendations for Preventive Pediatric Health Care - Bright Futures/American Academy of Pediatrics.*