

4 - 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:

Maternal & Birth History: ☐ Birth HX form reviewed
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

Standardized Screen Used? (Optional) ☐ Yes ☐ No

See instrument form: ☐ PEDS ☐ Ages & Stages

☐ Other: _____

DB Concerns: (e.g. crying/colic) _____

Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)

Visually tracks objects beyond midline	Y	N
Moves arms and legs equally	Y	N
Rolls over stomach to back	Y	N
Supports on wrists in prone	Y	N
ATNR (fencer position) no longer obligate	Y	N
Sits with support	Y	N

Fine Motor skills

Hands are unfisted	Y	N
Manipulates fingers	Y	N

Language/Socioemotional Skills

Vocalizes/Coos	Y	N
Orients to voice	Y	N
Laughs out loud	Y	N

Parent – Infant Interaction (maternal depression present in 50% of post-partum mothers):

Interaction appears age appropriate	Y	N
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Clinical concerns regarding interaction:

SENSORY SCREENING:

Any parent concerns about vision or hearing? ☐ Yes ☐ No

Vision:

Blinks in reaction to bright light: ☐ Yes ☐ No

Blinks in reaction to visual threat: ☐ Yes ☐ No (normal by 3 mos)

Hearing:

Responds to sounds: ☐ Yes ☐ No ☐ Left ☐ Right

PHYSICAL EXAMINATION (check box):

	N L	AB	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanel				
Eyes: Red Reflex, Appearance				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia/ Femoral Pulses				
Extremities, Clavicles, Hips				
Muscular				
Neuromotor				
Back/Sacral Dimple				

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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 (Oklahoma Tobacco Helpline:
1.800.QUIT.NOW) ☐ No sun exposure ☐ Fever management
☐ Other: _____

Violence Prevention:

- ☐ Adequate support system? ☐ Adequate respite? ☐ Feel safe in
neighborhood? ☐ Domestic Violence? ☐ No Shaking ☐ Gun Safety
☐ Other: _____

Sleep Safety Counseling:

- ☐ Sleep (on back) ☐ Sleep Safety
☐ Other: _____

Nutrition Counseling:

- ☐ Breast ☐ Formula ☐ Solids (4-6mo) ☐ 3-4 hour between feeding
☐ Less frequent stools typical for bottle fed infants ☐ 5-8 wet
diapers/day ☐ Vitamins ☐ No honey ☐ No bottle prop ☐ No
microwave ☐ No infant feeders
☐ Other: _____

What to anticipate before next visit:

- ☐ Sleep cycle gets more regular ☐ Change in feeding/stooling patterns
☐ Sitting alone by 6 mos ☐ Okay to add solids at 6 mos ☐ Back to work?
☐ Weaning? ☐ Temperament style ☐ Different rates of development are
normal ☐ Other: _____

PROCEDURES:

DENTAL REMINDER

PCP screen 1st tooth eruption

IMMUNIZATIONS DUE at this visit:

HepB2 (if needed) # _____

☐ Given ☐ Not Given ☐ Up to Date

DTap2 # _____

☐ Given ☐ Not Given ☐ Up to Date

Hib2 # _____

☐ Given ☐ Not Given ☐ Up to Date

IPV2 # _____

☐ Given ☐ Not Given ☐ Up to Date

PCV2 # _____

☐ Given ☐ Not Given ☐ Up to Date

Rotavirus2 # _____

☐ Given ☐ Not Given ☐ Up to Date

Reason Not Given if due: List Vaccine(s) not given:

- ☐ Vaccine not available _____
☐ Child ill _____
☐ Parent Declined _____
☐ Other _____

ASSESSMENT: ☐ Healthy, no problems

PLAN/RECOMMENDATIONS: ☐ Do vaccines/procedures marked above ☐ Other _____

☐ Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____

Date: _____