Oklahoma HealthCare Authority

15 Month Child Health Supervision (EPSDT) Visit

Patient Sticker

NAME:_____ DOB:_____ DOV:_____ AGE:_____ SEX:_____ MED REC#: _____

HT: _____(_____%)
WT: _____(_____%)
HC: _____(_____%)

Temp: _____ Pulse:_____ Meds: _____
Pulse Ox-Optional: _____
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
Standardized Screen Used? (Suggested by AAP) ❑Yes ❑No
See instrument form: ❑ PEDS ❑ Ages & Stages
❑ Other: _____
DB Concerns: (e.g. sleep/feeding) _____

_____
_____
_____

Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)		
Walks independently	**Y**	**N**
Creeps/crawls up stairs	**Y**	**N**
Fine Motor Skills		
Feed self, drinks from cup	**Y**	**N**
Scribbles spontaneously	**Y**	**N**
Language/Socioemotional/Cognitive Skills		
Says 3-6 words	**Y**	**N**
Understands simple commands	**Y**	**N**
Listens to a story	**Y**	**N**
Points to one or more body parts	**Y**	**N**
Cooperates while dressing	**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 regarding 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				
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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NAME: _____ DOB: _____
MED RECORD #: _____ DOV: _____

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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) ❑ Sun protection ❑ 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 Safety Counseling:
❑ Sleep Safety ❑ Read to infant (e.g. Reach out and Read)
❑ Other: _____

Nutrition Counseling:
❑ Breast ❑ Whole cow's milk until 2 yrs ❑ Feeding self solids/finger foods ❑ Vitamins ❑ No popcorn, peanuts, hard candy ❑ Limit juice (4 oz or less/day)
❑ Other:_____

What to anticipate before next visit:
❑ May want more independence (especially in feeding) ❑ Variable appetite ❑ Okay to allow infant to finger feed ❑ Child-proofing ❑ Discipline
❑ Different rates of development are normal ❑ Other:

PROCEDURES:
❑ Blood lead test **(if not previously tested)**
❑ TB test (if at risk)

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

IMMUNIZATIONS DUE at this visit:
Flu (yearly)
❑ Given ❑ Not Given ❑ Up to Date

Catch-up on vaccines
HepB #_____
❑ Given ❑ Not Given ❑ Up to Date
DTap #_____
❑ Given ❑ Not Given ❑ Up to Date
Hib #_____
I❑ Given ❑ Not Given ❑ Up to Date
IPV #_____
❑ Given ❑ Not Given ❑ Up to Date
PCV # _____
❑ Given ❑ Not Given ❑ Up to Date
MMRV #_____
❑ Given ❑ Not Given ❑ Up to Date
Hep A #_____
❑ 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: See 9 month form if child's mother was HEPBsAg positive

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:** _____