



6 - Month Child Health Supervision (EPSDT) Visit

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 _____

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 box):

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) _____

	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				

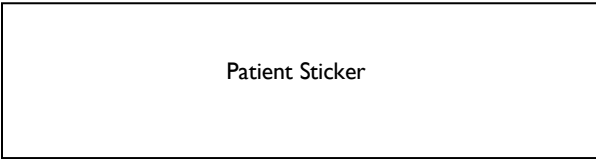
Clinician Observations/History: (Suggested options)

Motor Skills (observe head, trunk, and limb control)	
Visually tracks objects beyond midline	Y N
Moves arms and legs equally	Y N
Rolls over both ways	Y N
ATNR (fencer position) gone	Y N
Sits alone	Y N
Fine Motor Skills	
Reaches for and rakes at objects	Y N
Transfers objects hand to hand (by 5 mos)	Y N
Regards small wad of paper	
Language/Socioemotional Skills	
Babbles (vowel-consonant)	Y N
Raspberry noises (by 5 mos)	Y N
Says ah-goo (by 5 mos)	Y N
Parent - Infant Interaction	
Interaction appears age appropriate	Y N

Clinician concerns regarding interaction: _____

(EPSDT) 6 - Month Visit Page 2

NAME: _____ DOB: _____
MED RECORD #: _____ DOV: _____



Patient Sticker

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 Safety
- Other: _____

Nutrition Counseling:

- Breast Formula Solids 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 may get disturbed when stranger anxiety begins (around 9 mos)
- Change in feeding/stooling patterns Pulling up to cruise holding on to furniture by 9 mos
- Okay to allow infant to finger feed
- Back to work? Weaning? Temperament style Walkers Child-proofing
- Discipline Different rates of development are normal Other: _____

PROCEDURES:

DENTAL REMINDER

PCP screen 1st tooth eruption
Fluoride (check on type of water and public water supply content)

IMMUNIZATIONS DUE at this visit:

Information provided and consent for each on given

HepB3 (if needed) # _____

Given Not Given Up to Date

DTap3 # _____

Given Not Given Up to Date

Hib3 # _____

Given Not Given Up to Date

IPV3 # _____

Given Not Given Up to Date

PCV3 # _____

Given Not Given Up to Date

Rotavirus2 # _____

Given Not Given Up to Date

Flu (yearly)

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: _____