123 Child Development Center

Well Child Check Birth-4Years old

EPSDT Infancy Encounter Form (Newborn-9 mos)

Visit # ☐ 1mos ☐ 2mos ☐ 4mos ☐ 6mos ☐ 9mos

Child's Name:	Date of Birth:	Sex ☐ M ☐ F

History

Birth: ☐ Vaginal ☐ C-Section		**Nutrition** ☐ Breast ☐ Formula	Allergies: _____
☐ Complications: _____ _____	Birth Weight _____ Gestation _____	☐ Supplements: _____ Amounts _____ Frequency _____	Current Meds: _____ _____
Elimination:	**Sleep:**	**Sensory Screenings:**	Special Health Care Needs: _____
☐ Stool _____ ☐ Urine _____	☐ Normal ☐ Abnormal _____	Vision ☐ Normal ☐ Abnormal _____ Hearing ☐ Normal ☐ Abnormal _____	_____ _____

Comprehensive Exam

Date	Test	Results	Date	Test	Results
	Head Circumference			Height	
	Hematocrit/Hemoglobin			Weight	

	Normal for age	Abnormal	Not Eval.	Comments
a. General Appearance				
b. Skin				
c. Head/fontanels				
d. Eyes				
e. Ears				
f. Nose				
g. Oropharynx/throat				
h. Oral Health				
i. Lungs				
j. Heart				
k. Abdomen				
l. Genitalia				
m. Extremities				
n. Spine				
o. Neurological (1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				

Health Education/Anticipatory Guidance

Health	**Nutrition/Diet**	**Safety**	**Psychosocial/Behavior**
☐ No bottle in bed/bottle propping	☐ Increase Formula	☐ Sleeping on back	☐ Temperament
☐ Shaken baby prevention	☐ Cereal/Solids	☐ Car Seats-rear facing	☐ Methods to console baby: hold, cuddle
☐ Passive smoke/tobacco	☐ Colic/Fussiness/gas	☐ Crib Safety	☐ Infant Bonding: talk, sing, read, play
☐ Fever protocols	☐ Supplements	☐ Smoke detector	☐ Opportunities for exploration
☐ Weight	☐ Drinking from a cup	☐ Safe bathing/Safe water temp	☐ Develop Routines
☐ Immunizations	☐ Physical activity	☐ Toy Safety/Falls	
☐ TB		☐ Signs of illness/emergencies	
☐ Lead 12 mos and 24 mos		☐ Physical and emotional abuse	

Findings, treatment, recommendations, comments, other:

Physician Printed: _____	Physician Signature: _____	Date: _____

Received on: _____ Received By: _____ Entered on: _____

123 Child Development Center

Well Child Check Birth-4Years old

EPSDT Infancy Encounter Form (12 mos-4yrs.)

Visit # ☐ 12mos ☐ 15mos ☐ 18mos ☐ 24mos ☐ 3-4 yrs.

Child's Name:	Date of Birth:	Sex ☐ M ☐ F

History

Birth: ☐ Vaginal ☐ C-Section		**Nutrition** ☐ Breast ☐ Formula	Allergies: _____
☐ Complications: _____ _____	Birth Weight _____ Gestation _____	☐ Supplements: _____ Amounts_____Frequency_____	Current Meds: _____ _____
Elimination:	**Sleep:**	**Sensory Screenings**:	Special Health Care Needs: _____
☐ Stool _____ ☐ Urine _____	☐ Normal ☐ Abnormal _____	Vision ☐ Normal ☐ Abnormal _____ Hearing ☐ Normal ☐ Abnormal _____	_____ _____

Comprehensive Exam

Date	Test	Results	Date	Test	Results
	Blood Pressure			Height	
	Head Circumference			Weight	
	Hematocrit/Hemoglobin			BMI (>24m)	
	Lead test results 12 mos			**Lead test results 24 mos**	

	Normal for age	Abnormal	Not Eval.	Comments
a. General Appearance				**Attention: Please Fill out completely. State of NM EPSDT requires lead testing to take place at the 12 month exam AND the 24 month Please provide results of both.**
b. Skin				
c. Head/fontanels				
d. Eyes				
e. Ears				
f. Nose				
g. Oropharynx/throat				
h. Oral Health				
i. Lungs				
j. Heart				
k. Abdomen				
l. Genitalia				
m. Extremities				
n. Spine				
o. Neurological (1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				

Health Education/Anticipatory Guidance

Health	Nutrition/Diet	Safety	Psychosocial/Behavior
☐ No bottle in bed/bottle propping	☐ Milk	☐ Playground/yard safety	☐ Potty Training
☐ Shaken baby prevention	☐ Cereal/Solids	☐ Car Seats/boosters	☐ Developing Routines
☐ Passive smoke/tobacco	☐ Snacks	☐ Crib Safety	☐ Temperament
☐ Fever protocols	☐ Supplements	☐ Smoke detector	☐ Opportunities for exploration
☐ Weight/Physical Activity	☐ Self-Feeding	☐ Water safety	
☐ Immunizations	☐ Finger Foods	☐ Toy Safety/Falls	
☐ TB		☐ Signs of illness/emergencies	
☐ Lead 12 mos and 24 mos		☐ Physical and emotional abuse	

Findings, treatment, recommendations, comments, other:

Physician Printed:_____	Physician Signature:_____	Date: _____

Received on:_____ Received By:_____ Entered on: _____