2 – 14 Day Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – ***circle one*** 99381-New, 99391-Estab.

Accompanied by:	Allergies: ☐ NKA ____________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: ____________ Formula (type): ____________

Developmental Screen: Age Appropriate? (e.g., rooting reflex, startle, suck & swallow) Yes ________ No ________

If suspicious, specific objective testing performed ____________

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		
2nd Newborn PKU (>72 hrs) prenatal labs/history		

ASSESSMENT & PLAN:

IMMUNIZATIONS:

- **Was Hepatitis B given at birth?** **Yes** ________ **No** ________
- **Pt. needs immunizations?** **Yes** ________ **No** ________
- **Shot Record initiated?** **Yes** ________ **No** ________

ANTICIPATORY GUIDANCE

- ❑ Breast or formula, feeding frequency – amount
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/ “babyproofing”
- ❑ Safety with siblings and pets
- ❑ Drowning prevention
- ❑ Car seat/auto safety
- ❑ **“Shaken baby** syndrome”
- ❑ Signs of Illness
- ❑ Temperature taking, When to contact doctor
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ “Safe at home”
- ❑ Potential for abuse
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ **Parent/infant attachment**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth to Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06 **Bold** = First asked this age

1 Month Old	**Well Care Exam (EPSDT) Form**

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – ***circle one*** 99381-New, 99391-Estab
Accompanied by:	Allergies: ☐ NKA ___________________		Current Medication(s)		

				❑	❑
Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:	
Pulse:	
Resp:	

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: ______________________ Formula (type): ______________________

Developmental Screen: Age Appropriate? (e.g., responds to sounds, responds to parent's voice, follows with eyes?) Yes ______ No _____

If suspicious, specific objective testing performed ______________________

Behavioral Screen: Age appropriate? (parental interview) ______________________ Yes _________ No _________

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Was Hepatitis B given at birth?** **Yes** ________ **No** ________

Shot Record initiated? **Yes** _____ **No** _____

ANTICIPATORY GUIDANCE

- ❑ **Breastfeeding/Formula exclusive**
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/"Baby-proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ **Sun safety**
- ❑ Car seat/Auto safety
- ❑ **"Shaken baby syndrome"**
- ❑ Signs of Illness
- ❑ Temp. taking, when to call Dr.
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ **Child care safety**
- ❑ **Limit TV/Video exposure**
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ **Parent/infant attachment**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth to Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age

2 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – ***circle one*** 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA ___________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Temp:
Pulse:
Resp:

Parental Comments/Concerns:

Fluoride checked? (if well water)

Nutritional Screen: Breast Feeding: ______________ Formula (type): ______________

Developmental Screen: Age Appropriate? (e.g., smiles responsively, lifts head, vocalizes in play?) Yes _____ No _____

If suspicious, specific objective testing performed ______________

Behavioral Screen: Age appropriate? (parental interview) ______________ Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** ___ **Deferred?** ___

Given today? Hep B ___ **DTaP** ___ **IPV** ___ **Hib** ___ **PCV** ___ **Other** ___

ANTICIPATORY GUIDANCE

- ❑ Breastfeeding/Formula exclusive
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/“Baby-proofing”
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ **Sun safety**
- ❑ Car seat/Auto safety
- ❑ “Shaken baby syndrome”
- ❑ Signs of illness
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ “Safe at home”
- ❑ Potential for abuse
- ❑ Childcare safety
- ❑ Limit TV/Video exposure
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ Parent/Infant attachment
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06 **Bold** = First asked this age

4 Month Old Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA ________________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: ____________________________ Formula (type): ____________________________

Developmental Screen: Age Appropriate? (e.g., babbles & coos, rolls front to back, controls head well) Yes __________ No ______

If suspicious, specific objective testing performed ____________________________

Behavioral Screen: Age appropriate? (parental interview) ____________________________ Yes __________ No ______

PHYSICAL EXAM

Are the following normal?	**Normal**	**Describe abnormal findings:**
Skin/Hair/Nails		
Ear/Hearing (Hospital screening done?)		
Eyes/Vision (red reflex)		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _____ **No** _____ **Delayed?** _____ **Deferred?** _____

Given today? Hep B ____ **DTaP** _____ **IPV** _____ **Hib** ________ **PCV** _____ **Other** ____________

ANTICIPATORY GUIDANCE

- ❑ **May introduce baby food slowly**
- ❑ Early dental decay
- ❑ Supine sleep position
- ❑ Injury prevention/"Baby-proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ Sun safety
- ❑ Car seat/Auto safety
- ❑ "Shaken baby syndrome"
- ❑ Signs of illness
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting practices
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ Child care safety
- ❑ Limit TV/Video exposure
- ❑ Postpartum adjustment
- ❑ Family involvement
- ❑ **Fears and phobias**
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Update 1-06

Bold = First asked this age

6 Month Old — Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – *circle one* 99381-New, 99391-Estab

Accompanied by:	Allergies: ☐ NKA ______________	Current Medication(s)

Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:

HISTORY:

Parental Comments/Concerns:

Temp:	
Pulse:	
Resp:	
Fluoride checked? (if well water)	

Nutritional Screen: Breast Feeding: ______________ Formula (type): ______________ Solids: ______________

Developmental Screen: Age Appropriate? (e.g., rolls over, transfers small objects, vocal imitation) Yes ________ No ________

If suspicious, specific objective testing performed ______________

Behavioral Screen: Age appropriate? (parental interview) ______________ Yes ________ No ________

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:
Skin/Hair/Nails		
Ear/Hearing		
Eyes/Vision		
Mouth/Throat/Teeth		
Nose/Head/Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Extremities		
Back/Hips		
Neurological		

SCREENINGS:

Verbal Lead Risk Assessment

Yes/ No

ASSESSMENT & PLAN:

IMMUNIZATIONS: Pt. needs immunizations? Yes ___ No _____ Delayed? ________ Deferred? ________

Given today? Hep B _____ DTaP _____ IPV _____ Hib __ PCV _____ Other _______ Influenza ________

ANTICIPATORY GUIDANCE

- ❑ **Finger foods**
- ❑ **Introduce cup use**
- ❑ **Teething**/Early dental decay
- ❑ **Dental gum care**
- ❑ Supine sleep position
- ❑ Injury prevention/ "Baby - proofing"
- ❑ Safety with siblings and pets
- ❑ Drowning prevention/ Sun safety
- ❑ Car seat/Auto safety
- ❑ "Shaken baby syndrome"
- ❑ Emergency/911
- ❑ Passive smoke
- ❑ Parenting advice
- ❑ "Safe at home"
- ❑ Potential for abuse
- ❑ Child care safety
- ❑ Limit TV/Video exposure
- ❑ Family involvement
- ❑ **Interaction with parents**
- ❑ **Parental/Sibling adjustment**
- ❑ Fears and phobias
- ❑ **Next appointment**

REFERRALS: ❑ **WIC** ❑ **Birth-to-Three** ❑ **Specialty** ❑ **Other**

Date Consult Report Received:

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note? Yes No

Bold = First asked this age