

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – <i>circle one</i> 99382-New, 99392-Estab
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Accompanied by:	Allergies: <input type="checkbox"/> NKA _____	Current Medication(s)
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Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:
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HISTORY:	Temp: _____
	Pulse: _____
	Resp: _____
Parental Comments/Concerns:	Fluoride checked? (if well water)

Dental Screen:	Daily tooth brushing? Yes No	Frequency of sugar intake, & snacks low in sugar, discussed? Yes No
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Nutritional Screen: Breast Feeding: _____	Formula (type): _____	Supplements: _____	Solids: _____
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PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test
Ear/Hearing			(perform if at risk)
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test/referral (if not done at 9 mos.)
Nose/Head/Neck			Additional Labs Ordered:
Lungs			Hgb/Hct (HRisk/WIC) _____
Heart			Urinalysis _____
Abdomen			Other: _____
Genitourinary			Behavioral /Developmental Screen
Extremities			<input type="checkbox"/> Home Environment
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other tool)
Neurological			<input type="checkbox"/> Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS	Pt. needs immunizations?	Yes _____	No _____	Delayed? _____	Deferred? _____
Given today?	Hep _____	Hib _____	IPV _____	PCV _____	Influenza _____ DTap _____ MMR _____

ANTICIPATORY GUIDANCE PROVIDED

<input type="checkbox"/> Nutrition/Self-feeding	<input type="checkbox"/> Drowning Prevention /sun safety	<input type="checkbox"/> Parenting Advice	<input type="checkbox"/> Social interactions/ expectations
<input type="checkbox"/> Transition to cup	<input type="checkbox"/> Car seat/auto safety	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Sibling interactions
<input type="checkbox"/> Dental caries prevention	<input type="checkbox"/> Emergency/911	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Family functioning
<input type="checkbox"/> Sleep practices	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Limit TV/video Exposure	<input type="checkbox"/> Parental Adjustment
<input type="checkbox"/> "Babyproofing"/Poison Control #	<input type="checkbox"/> "Safe at Home?"	<input type="checkbox"/> Time with parents/reading	<input type="checkbox"/> Next appointment
<input type="checkbox"/> Safety with Siblings and Pets		<input type="checkbox"/> Stranger Awareness	

REFERRALS:	<input type="checkbox"/> WIC	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Dental	<input type="checkbox"/> Nutritional
	<input type="checkbox"/> Specialty	<input type="checkbox"/> Other _____	Date Consult Report Received:		

Clinician Name (print)	Clinician Signature	See Additional/Supervisory Note? Yes No
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Date	Last Name:	First Name:	Date of Birth	Age	Proc. code – <i>circle one</i> 99382-New, 99392-Estab
Accompanied by:		Allergies: <input type="checkbox"/> NKA _____		Current Medication(s)	
Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile: BMI: Percentile:
HISTORY:					Temp: _____
					Pulse: _____
					Resp: _____
Parental Comments/Concerns:					Fluoride checked? (if well water)
Dental Screen:	Daily toothbrushing?	Yes	No	Education re: Frequency of sugar intake/ Healthy Snacks?	Yes No
Nutritional Screen:	Breast/whole milk:	Table foods:	Supplements:	Cup:	
PHYSICAL EXAM					
Are the following normal?	Normal	Describe abnormal findings:		LABS ORDERED:	
Skin/Hair/Nails				Tuberculin Test _____	
Ear/Hearing				(perform if at risk)	
Eyes/Vision				Verbal Lead Risk Assessment	
Mouth/Throat/Teeth				Blood lead test (if not previously done)	
Nose/Head/Neck				Additional Labs Ordered:	
Lungs				Hgb/Hct (HRisk/WIC)	
Heart				Urinalysis	
Abdomen				Other:	
Genitourinary				Behavioral /Developmental Screen	
Extremities				<input type="checkbox"/> Home Environment	
Back/Hips				<input type="checkbox"/> General Screen (e.g. PEDS or other tool)	
Neurological				<input type="checkbox"/> Activities (risk level)	
ASSESSMENT & PLAN:					
Pt. needs immunizations?					
IMMUNIZATIONS:	Yes _____	No _____	Delayed? _____	Deferred? _____	Influenza _____
Given today?	Hep B _____	DTaP _____	Hib _____	IPV _____	MMR _____
				Varicella _____	PCV _____
ANTICIPATORY GUIDANCE PROVIDED					
<input type="checkbox"/> Nutrition/Exercise	<input type="checkbox"/> Car seat/auto safety	<input type="checkbox"/> "Safe at Home?"	<input type="checkbox"/> Sibling interactions		
<input type="checkbox"/> Dental caries prevention	<input type="checkbox"/> Fire Safety	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Family functioning		
<input type="checkbox"/> Sleep practices	<input type="checkbox"/> Emergency/911	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Parental Adjustment		
<input type="checkbox"/> Injury prevention/"Child-proofing"	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Time with parents/reading	<input type="checkbox"/> Social interactions/Expectations		
<input type="checkbox"/> Drowning Prevention /sun safety	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Limit TV/Video Exposure	<input type="checkbox"/> Next appointment		
REFERRALS:					
<input type="checkbox"/> Specialty	<input type="checkbox"/> WIC	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Dental	<input type="checkbox"/> Nutritional
	<input type="checkbox"/> Other	Date Consult Report Received:			
Clinician Name (print)		Clinician Signature		See Additional/supervisory Note? Yes No	

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>-circle one</i> 99382-New, 99392-Estab		
Accompanied by:		Allergies: <input type="checkbox"/> NKA _____		Current Medication(s)			
Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:

HISTORY:

Temp:

Pulse:

Resp:

Parental Comments/Concerns:

Fluoride checked? (if well water)

Dental Screen: Daily tooth brushing? Frequency of sugar intake, & snacks low in sugar, discussed? Yes No

Nutritional Screen: Breast/whole milk: Table foods: Supplements: Cup:

Hearing Screen: Within normal limits (ABR, OAE): Yes No **Speech:** Within normal limits? Yes No

PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test
Ear/Hearing			(perform if at risk)
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test (if not previously done)
Nose/Head/Neck			Additional Labs Ordered:
Lungs			Hgb/Hct (HRisk/WIC) _____
Heart			Urinalysis _____
Abdomen			Other: _____
Genitourinary			Behavioral /Developmental Screen
Extremities			<input type="checkbox"/> Home Environment
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other tool)
Neurological			<input type="checkbox"/> Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS: Pt. needs immunizations? Yes ___ No ___ Delayed? ___ Deferred? ___
 Given today? DTaP ___ Varicella ___ Influenza ___ HIB ___ Other ___

ANTICIPATORY GUIDANCE PROVIDED

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Nutrition/exercise/vit. | <input type="checkbox"/> Drowning Prevention /sun safety | <input type="checkbox"/> Parenting advice | <input type="checkbox"/> Sibling interactions |
| <input type="checkbox"/> Dental caries prevention | <input type="checkbox"/> Car seat/auto safety | <input type="checkbox"/> "Safe at Home?" | <input type="checkbox"/> Family functioning |
| <input type="checkbox"/> Sleep practices | <input type="checkbox"/> Fire Safety | <input type="checkbox"/> Potential for abuse | <input type="checkbox"/> Social interactions/ Expectations |
| <input type="checkbox"/> Injury prevention/ "Childproofing" | <input type="checkbox"/> Violence/Prev.Gun Safety | <input type="checkbox"/> Child Care Safety | <input type="checkbox"/> Limit Setting |
| <input type="checkbox"/> Safety with Siblings and Pets | <input type="checkbox"/> Emergency/911 | <input type="checkbox"/> Time with parents/reading | <input type="checkbox"/> Next appointment |
| | <input type="checkbox"/> Passive Smoke | <input type="checkbox"/> Limit TV/Video Exposure | |

REFERRALS: WIC Behavioral Birth to Three Dental Nutritional
 Speech Specialty Other **Date Consult Report Received:**

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

24 Month Old

Well Care Exam (EPSDT) Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. code <i>—circle one</i> 99382-New, 99392-Estab
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Accompanied by:	Allergies: <input type="checkbox"/> NKA _____	Current Medication(s)
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Weight:	Percentile:	Height:	Percentile:	Head Circ:	Percentile:	BMI:	Percentile:
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HISTORY:	Temp:	
	Pulse:	
	Resp:	

Parental Comments/Concerns:	Fluoride checked? (If well water)
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Dental Screen: Routine:	Urgent:	Parent advised:	Brushing teeth? Yes	No
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Nutritional Screen:	Adequate _____	Inadequate _____	Supplements: _____
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Hearing Screen: Within normal limits (ABR, OAE):	Yes	No	Speech: Within normal limits?	Yes	No
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PHYSICAL EXAM

Are the following normal?	Normal	Describe abnormal findings:	LABS ORDERED:
Skin/Hair/Nails			Tuberculin Test
Ear/Hearing			(perform if at risk)
Eyes/Vision			Verbal Lead Risk Assessment
Mouth/Throat/Teeth			Blood lead test referral
Nose/Head/Neck			Additional Labs Ordered:
Lungs			Hgb/Hct (HRisk/WIC) _____
Heart			Urinalysis _____
Abdomen			Other: _____
Genitourinary			Behavioral /Developmental Screen
Extremities			<input type="checkbox"/> Home Environment
Back/Hips			<input type="checkbox"/> General Screen (e.g. PEDS or other tool)
Neurological			<input type="checkbox"/> Activities (risk level)

ASSESSMENT & PLAN:

IMMUNIZATIONS:	Pt. needs immunizations?	Yes _____	No _____	Delayed? _____	Deferred? _____
Given today?	Hep B _____	Varicella _____	Influenza _____	HIB _____	Other _____

ANTICIPATORY GUIDANCE PROVIDED			
<input type="checkbox"/> Nutrition/exercise/vitamins	<input type="checkbox"/> Drowning Prevention /sun safety	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Family involvement
<input type="checkbox"/> Dental caries prevention/ dental care	<input type="checkbox"/> Car seat/auto safety	<input type="checkbox"/> "Safe at Home?"	<input type="checkbox"/> Fears and Phobias
<input type="checkbox"/> Discontinue Pacifier Use	<input type="checkbox"/> Violence Prevention/gun safety	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Peer Companionship
<input type="checkbox"/> Injury prevention/ "Childproofing"	<input type="checkbox"/> Fire Safety/ Burns	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Self control
<input type="checkbox"/> Poisonous Plant Awareness	<input type="checkbox"/> Emergency/911	<input type="checkbox"/> Toilet training	<input type="checkbox"/> Sexual self-awareness
<input type="checkbox"/> Safety with Siblings and Pets	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Read to child	<input type="checkbox"/> Next appointment
		<input type="checkbox"/> Limit TV/Video exposure	

REFERRALS:	<input type="checkbox"/> WIC	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Dental	<input type="checkbox"/> Nutritional
<input type="checkbox"/> Speech	<input type="checkbox"/> Specialty	<input type="checkbox"/> Other	Date Consult Report Received:		

Clinician Name (print)	Clinician Signature	See Additional/Supervisory Note? Yes No
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3 Year Old

Well Care EPSDT Tracking Form

Date	Last Name:	First Name:	Date of Birth	Age	Proc. Code – circle one 99382-New, 99392-Estab						
Accompanied by:		Allergies: <input type="checkbox"/> NKA _____		Current Medication(s)							
Weight:	Percentile:	Height:	Percentile:	BMI:	Percentile:						
HISTORY:				Vision Exam (if able)							
				<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>OD _____</td> <td>Temp: _____</td> </tr> <tr> <td>OS _____</td> <td>Pulse: _____</td> </tr> <tr> <td>OU _____</td> <td>Resp: _____</td> </tr> <tr> <td>Corrected / uncorrected</td> <td>BP : _____</td> </tr> <tr> <td> </td> <td>Fluoride checked? (If well water)</td> </tr> </table>		OD _____	Temp: _____	OS _____	Pulse: _____	OU _____	Resp: _____
OD _____	Temp: _____										
OS _____	Pulse: _____										
OU _____	Resp: _____										
Corrected / uncorrected	BP : _____										
	Fluoride checked? (If well water)										
Parental Comments/Concerns:											
Dental Screen:		Next appt:	Routine	Urgent	Parent advised						
Date of Last exam/referral:				Brushing child's teeth?							
Nutritional Screen: Adequate		Inadequate	Supplements:		Physical Activity:						
Hearing Screen: Within normal limits? (Audiometry)		Yes	No	Speech: Within Normal Limits? Yes No							
PHYSICAL EXAM											
Are the following normal?	Normal	Describe abnormal findings:		LABS ORDERED:							
Skin/Hair/Nails				Tuberculin Test							
Ear/Hearing				(perform if at risk)							
Eyes/Vision				Verbal Lead Risk Assessment							
Mouth/Throat/Teeth				Blood lead test (If not done at age 24 months) _____							
Nose/Head/Neck				Additional Labs Ordered:							
Lungs				Hgb/Hct (HRisk/WIC) _____							
Heart				Urinalysis _____							
Abdomen				Other: _____							
Genitourinary				Behavioral /Developmental Screen							
Extremities				<input type="checkbox"/> Home Environment							
Back/Hips				<input type="checkbox"/> General Screen (e.g. PEDS or other tool)							
Neurological				<input type="checkbox"/> Activities (risk level)							
				<input type="checkbox"/> School Readiness							
ASSESSMENT & PLAN: (Confidential Documentation attached)											
IMMUNIZATIONS											
Given Today? _____		Hep B _____	Varicella _____	PCV _____							
Hep A _____		Influenza _____	Other _____								
ANTICIPATORY GUIDANCE PROVIDED											
<input type="checkbox"/> Nutrition/ exercise/ vitamins	<input type="checkbox"/> Car Seat /Auto safety	<input type="checkbox"/> "Safe at home?"	<input type="checkbox"/> Family involvement								
<input type="checkbox"/> Dental care	<input type="checkbox"/> Sport bike/helmet use	<input type="checkbox"/> Potential for abuse	<input type="checkbox"/> Limits/Consequences								
<input type="checkbox"/> Injury Prevention/"Childproofing	<input type="checkbox"/> Violence Prev./Gun Safety	<input type="checkbox"/> Child Care Safety	<input type="checkbox"/> Social Interactions/ Expectations								
<input type="checkbox"/> Poisonous Plant Awareness	<input type="checkbox"/> Pedestrian/Traffic Safety	<input type="checkbox"/> Reading/ Preschool	<input type="checkbox"/> Sexual Self-awareness								
<input type="checkbox"/> Safety with Siblings and Pets	<input type="checkbox"/> Emergency/911	<input type="checkbox"/> Toilet training	<input type="checkbox"/> Peer Companionship								
<input type="checkbox"/> Drowning Prevention/Sun Safety	<input type="checkbox"/> Passive Smoke	<input type="checkbox"/> Limit TV/Video/ Exposure	<input type="checkbox"/> Next appointment								
	<input type="checkbox"/> Parenting advice	<input type="checkbox"/> Discourage Thumbsucking									
REFERRALS:											
<input type="checkbox"/> WIC	<input type="checkbox"/> Behavioral/ Developmental	<input type="checkbox"/> Dental	<input type="checkbox"/> Nutritional								
<input type="checkbox"/> Speech	<input type="checkbox"/> Other _____	Date Consult Report Received:									
Clinician Name (print)		Clinician Signature		See Additional/Supervisory Note? Yes No							