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| **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 | | | |  | | | |  | |  | | **If you have any questions please feel free to call YDI Early Head Start at**  **Phone:** 212-7212 **Fax:** 268-0457 | | | | | | |
| 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: | |

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| **EPSDT Infancy Encounter Form (12 mos-3 yrs.)** | | | | | | | | | | | | | Visit # ☐ 12mos ☐ 15mos ☐ 18mos ☐ 24mos ☐ 3 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.**  **If you have any questions please feel free to call YDI Early Head Start at**  **Phone:** 212-7212 **Fax:** 268-0457 | | | | | | |
| 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: | | |