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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:  |