

NAME:
DOB:
GENDER: MALE FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues, including Post-partum Depression Screening (use of validated tool required): EPDS PPDS PHQ-9 Other P F
Findings:

DEVELOPMENTAL SURVEILLANCE

- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:

Breastmilk
Min per feeding: _____ Number of feedings in last 24 hrs: _____
Formula (type) _____
Oz per feeding: _____ Number of feedings in last 24 hrs: _____
Water source: _____ Fluoride: Y N

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

Up to date Deferred
Reason:

Given today: Hep B

LABORATORY

Newborn screening panel ordered today
Deferred - Reason:

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _____ (_____ %) Length: _____ (_____ %)
Head Circumference: _____ (_____ %)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

Appearance	Mouth/throat	Extremities
Head/fontanelles	Neck	Back
Skin	Heart/pulses	Musculoskeletal
Eyes	Lungs	Hips
Ears	Abdomen	Neurological
Nose	Genitalia	

Abnormal findings:

Newborn Hearing Screening:

ABR OAE Unknown
Completion date: ____/____/____ Results:

SENSORY SCREENING:

Subjective Hearing Screening: P F
Subjective Vision Screening: P F

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

Selected health topics addressed in any of the following areas*:

- Infant/Family Adjustment
- Parental/Maternal Well-Being
- Safety
- Nutrition/Feeding Routines

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Signature/title

Name: Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

2 Week Checkup

- Clean mouth with soft cloth twice a day
- Maintain consistent family routine
- No bed sharing
- No bottle in bed
- Skin, circumcision, umbilical care
- Sleep in crib on back with no loose covers
- Stooling-color, frequency
- Talk to infant using simple words telling/reading stories
- 6-8 wet diapers a day
- Adequate weight gain
- Hold to bottle-feed, no bottle propping
- No microwave to heat milk
- Store breast milk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Postpartum checkup
- Postpartum depression/family stress
- Crib safety with slats $\leq 2\text{-}3/8"$
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning
- Keep hand on infant when on bed or changing on table/couch
- No shaking baby (Shaken Baby Syndrome)
- Second-hand smoke
- Provide safe/quality day care, if needed
- Report domestic violence
- Return to work/school
- Thermometer use
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds
- Water heater at $<120^\circ$

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No
Ages Birth to 3 months		<ul style="list-style-type: none"> Gives a startle response to loud, sudden noises within 3 feet Calms to a familiar, friendly voice Wakes up when you speak or make noise nearby Coos and gurgles Laughs and uses voice when playing Watches your face when spoken to

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI Physician Referral and Orders for Early Childhood Intervention (ECI) form is available at:

<https://hhs.texas.gov/services/disability/early-childhood-intervention-services/eci-information-health-medical-professionals>