AmeriChoice AMERIGROUP Health Net Horizon NJ Health UHP other_________________(08/04)

New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

INFANCY: 2 –6 WEEKS

DATE:

Child's Name:	Date of Birth:
Allergies:	Current Medications:
Illnesses/Accidents/Problems/Concerns since birth:	

Yes	No		Yes	No	
☐	☐	My baby is sleeping well	☐	☐	My baby looks at my face
☐	☐	My baby is eating, sucking well	☐	☐	When crying, my baby can be calmed by being talked to or held
☐	☐	My baby can hear sounds	☐	☐	I am concerned that I have frequent times of sadness

WEIGHT KG/LB PERCENTILE:	BIRTH WEIGHT	HEIGHT CM/IN PERCENTILE:	HEAD CIR. PERCENTILE:

☐ Review of Systems ☐ Review of Family History-Birth Weight

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Screening	N	A	
Hearing	☐	☐	______________________
Vision	☐	☐	______________________
Development	☐	☐	______________________
Behavior	☐	☐	______________________
Social/Emotional	☐	☐	______________________
Gross Motor	☐	☐	______________________
Fine Motor	☐	☐	______________________

Physical	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head/Fontanelle	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Dental Structure/Tongue	☐	☐	Neurological	☐	☐
Mental Health	☐	☐			

Describe findings:

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Diet: ☐ Breast Milk ☐ Formula ______________________

Feedings: Amount _____________ Frequency _______________

☐ Newborn Hearing Screening Results

☐ Metabolic/Hemoglobinopathy Screening Results

☐ Review Immunization Record

☐ WIC Referral

Elimination: ______________________________________

Sleep: ______________________________________

Other: ______________________________________

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Family Planning	☐ No Bottle in Bed
☐ Development	☐ Sleeping on Back
☐ Infant Bond	☐ Shaken Baby Syndrome
☐ Passive Smoke	☐ Fever Protocols
☐ Appropriate Car Seat	☐ Child Care Issues
☐ Safety (general)	☐ Oral HealthCare
☐ Crib Safety	☐ Honey Restrictions
☐ Feeding/Colic	

Other: ______________________________________

Assessment:

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Diagnosis:

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Treatment Plan:

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REFERRALS:

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IMMUNIZATIONS: ☐ given (see VFC Form) ☐ up to date

NEXT VISIT: 2 MONTHS OF AGE

Health Provider Signature: