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

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

INFANCY: 9 MONTHS

DATE:

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

Yes	No		Yes	No	
☐	☐	My baby can feed self with fingers	☐	☐	My baby can move around on his/her own
☐	☐	My baby understands some words	☐	☐	My baby can play games like peek-a-boo or pat-a-cake
☐	☐	My baby awakens at night	☐	☐	My baby can see and hear
☐	☐	I am concerned that I have frequent times of sadness			

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

☐ Review of Systems ☐ Review of Family History

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____
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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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____
____
____
____
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Diet:____

☐ Vitamin Supplement ☐ WIC Referral
☐ Fluoride Supplement ☐ Hgb/Hct
☐ Review Immunization Record
☐ Lead Risk Assessment (verbal)

Elimination: ____

Sleep: ____

Other: ____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Family Planning	☐ Safety (general)
☐ No Bottle in Bed	☐ Development Benchmarks
☐ Crib Safety	☐ Shaken Baby Syndrome
☐ Fever Protocols	☐ Feeding/Colic
☐ Bedtime Ritual	☐ Oral Health Care
☐ Stranger Anxiety	☐ Language Stimulation
☐ Child Care Issues	☐ Appropriate Car Seat
☐ Lead Poison Prevention	☐ Passive Smoke

Other: ____

Assessment:

____
____

Diagnosis:

____

Treatment Plan:

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____
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REFERRALS:

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

NEXT VISIT: 12 MONTHS OF AGE

Health Provider Signature: