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

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

INFANCY: 12 MONTHS

DATE:

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

Yes	No		Yes	No	
☐	☐	My baby drinks from a cup	☐	☐	My baby can make sounds
☐	☐	My baby eats a variety of foods	☐	☐	My baby pulls self to standing position
☐	☐	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

_____

_____

_____

_____

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	☐	☐
Mental Health	☐	☐			

Describe findings:

_____

_____

_____

_____

_____

_____

_____

Diet:_____

☐ Vitamin Supplement ☐ Hgb/Hct
☐ Fluoride Supplement ☐ WIC Referral
☐ Blood Lead Screen ☐ Dental Referral
☐ Review Immunization Record
☐ TB Test (if high risks factor present)

Elimination: _____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance: (CHECK ALL COMPLETED)

☐ Family Planning ☐ Safety (general)
☐ Passive Smoke ☐ Development Benchmarks
☐ Crib Safety ☐ Appropriate Car Seat
☐ Fever Protocols ☐ Feeding/Colic
☐ Weaning ☐ Oral Health Care
☐ Discipline Limits ☐ Language Stimulation
☐ Child Care Issues ☐ Bath Safety
☐ Lead Poisoning Prevention

Other: _____

Assessment:

_____

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

_____

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

NEXT VISIT: 15 MONTHS OF AGE

Health Provider Signature: