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

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

CHILDHOOD: 18 MONTHS

DATE:

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

Yes	No		Yes	No	
☐	☐	My child feeds self	☐	☐	My child waves "bye bye"
☐	☐	My child can say 6 – 12 words	☐	☐	My child can follow simple directions

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	☐	☐	Neurological	☐	☐

Describe findings:

_____

_____

_____

_____

_____

_____

_____

Diet:_____

☐ Vitamin Drops with Iron ☐ Dental Referral

☐ Fluoride Supplements ☐ WIC Referral

☐ Review Immunization Record

☐ TB Test (if high risk factors present)

☐ Lead Risk Assessment (verbal)

Elimination: _____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Nutrition ☐ Toilet Training

☐ Safety (general) ☐ Passive Smoke

☐ Car Seat or Booster Seat ☐ Oral Health Care

☐ Development Benchmarks ☐ Discipline/Limits

☐ Language Development ☐ Lead Poisoning Prevention

☐ Bath Safety ☐ Supervision

☐ Child Care Issues

Other: _____

Assessment:

_____

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

_____

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

NEXT VISIT: 24 MONTHS OF AGE

Health Provider Signature: