

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/MENTAL HEALTH SCREENING:

Use of standardized tool: ASQ PEDS P F
Findings:

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
* Solids
See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

Up to date Deferred
Reason (if deferred):

Given today: DTaP Hep B Hib IPV
PCV Meningococcal* Hib-Hep B
DTaP-IPV-Hep B DTaP-IPV/Hib Influenza

**Special populations: See ACIP*

LABORATORY

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	Genitalia
Head/fontanel	Teeth	Extremities
Skin	Neck	Back
Eyes	Heart/pulses	Musculoskeletal
Ears	Lungs	Hips
Nose	Abdomen	Neurological

Abnormal findings:

SENSORY SCREENING:

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

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

Selected health topics addressed in any of the following areas*:
• Family Interaction • Nutrition/Feeding Routine
• Safety • Infant Development/Behavior

**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

9 Month Checkup

- Lead risk assessment*
- Establish consistent bedtime routine
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Provide nap time daily
- Read books and talk about pictures/story using simple words
- Separation anxiety common
- Use distraction or choice of 2 appropriate options for discipline
- Introduce cup and encourage use to begin weaning process
- No bottle in bed
- Slowly increase choice of solids
- Cut table foods small, no hot dogs cut into circles
- Do not leave alone in bath water
- Empty all buckets containing water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach, remove all buckets
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Remove small toys/pins/plastic pieces to allow safe exploration
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No
Ages 6 to 9 months		Turns and looks to you when you are speaking in a quiet voice Waves when you say "bye-bye" Stops for a moment when you say "no-no" Looks at objects or pictures when someone talks about them Babbles song-like tunes Uses voice to get your attention instead of crying Uses different sounds and appears to be naming things

***LEAD RISK FACTORS**

Perform a blood lead test if parent/caretaker answers "Yes/Don't Know" to any of the questions below.	Yes	Don't know	No
• Child lives in or visits a home, day care, or other building built before 1978 or undergoing repair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Pica (eats non-food items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Family member with an elevated blood lead level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Child is a newly arrived refugee or foreign adoptee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (see Pb-110 for a list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Food sources (including candy) or remedies (see Pb-110 for a list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Imported or glazed pottery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Cosmetics that may contain lead (see Pb-110 for a list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The use of Form Pb-110 (Lead Risk Questionnaire) is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm.

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>

ECHR-9M