**PEDIATRIC VISIT 12 to 14 MONTHS** DATE OF SERVICE

NAME

M / F DATE OF BIRTH

AGE

WEIGHT / % HEIGHT / % HC / % TEMP

**HISTORY REVIEW/UPDATE:** *(note changes)*

Medical history updated? Family health history updated? Reactions to immunizations? Yes / No Concerns:

# PSYCHOSOCIAL ASSESSMENT:

## Sleep: Child care:

**Recent changes in family:** *(circle all that apply)*

New members, separation, chronic illness, death, recent move, loss of job, other

**Environment:** Smokers in home? Yes / No

## Violence Assessment:

History of injuries, accidents? Yes / No Evidence of neglect or abuse? Yes / No

**RISK ASSESSMENT: (**by questionnaire)

**TB** (required @ 12 mos.) **LEAD**

Pos / Neg Pos / Neg

## PHYSICAL EXAMINATION: (unclothed)

Wnl Abn *(describe abnormalities)*

**** **** Appearance/Interaction

**** **** Growth

**** **** Skin

**** ****

# NUTRITIONAL ASSESSMENT:

**Typical diet**: *(specify foods)*:

**Education:** Phase out bottle **** Table foods **** Vitamins ****

Decreased appetite **** Whole milk until age two ****

Keep offering new foods **** Nutritious snacks ****

**DEVELOPMENTAL SCREENING:** *(With Standardized Tool)* **ASQ: ** **PEDs ** **Other: ** *(specify)* **Results:** Pass/Fail (circle)

##  Areas of Concern:

**Referred:** Yes / No **Where**?

**DEVELOPMENTAL SURVEILLANCE:** *(****O****bserved or* ***R****eported)*

**Social**: Fear of strangers **** Separation anxiety ****

**Fine Motor:** Scribbles **** Pincer grasp **** Drinks from cup ****

**Language:** Dada or Mama (specific) **** 1 to 3 words ****

Indicates wants ****

**Gross Motor:** Stands alone **** “Cruises” **** Walks **** Stoops and recovers **** Plays ball with examiner ****

# ANTICIPATORY GUIDANCE:

**Social:** Fear of strangers **** Separation anxiety ****

**Parenting:** Delay toilet training **** Negativism **** Autonomy ****

Discipline means to teach **** Avoid spanking/slapping ****

**Play and communication:** Varied activities ****

Head/Face

**** **** Eyes/Red reflex/Cover test

**** **** Ears

**** **** Nose

**** **** Mouth/Dental/Number of teeth

Singing, naming, reading ****

**Health**: Fever **** Fluoride if well water **** Brush teeth ****

Second hand smoke **** Use sunscreen ****

**Injury prevention:** Infant car seat **** Rear riding seat ****

 Hot liquids **** Hot water set at 120º **** Water safety (tub, pool) ****

**** **** Neck/Nodes

**** **** Lungs

Choking/suffocation **** Poison control # **** Baby proof home ****

Firearms (owner risk/safe storage) **** Fall prevention (heights) ****

 Don’t leave unattended **** Smoke detector/escape plan ****

**** **** Heart/Pulses

**** **** Chest/Breasts

# PLANS/ORDERS/REFERRALS

 1. Immunizations ordered ****

**** **** Abdomen

**** **** Genitals

**** ****

1. Lead test/HCT required ****
2. PPD/Other, if positive risk assessment ****

Musculoskeletal

**** **** Neuro/Reflexes/Tone

**** **** Vision *(gross assessment)*

**** **** Hearing *(gross assessment)*

1. Dental visit advised 
2. Fluoride Varnish Applied? Yes / No
3. Next preventive appointment at 15 months ****
4. Referrals for identified problems? *(specify)*

**Signatures:**

*https://mmcp.health.maryland.gov/epsdt/Pages/Home.aspx* ***Maryland Healthy Kids Program*** *2020*