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

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

INFANCY: 2 MONTHS

DATE:

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

Yes	No		Yes	No	
☐	☐	My baby is sleeping well	☐	☐	My baby makes cooing sounds
☐	☐	My baby is eating, sucking well	☐	☐	My baby lifts his/her head while on tummy
☐	☐	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-Birth Weight

_____

_____

_____

_____

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:

_____

_____

_____

_____

_____

Diet: ☐ Breast Milk ☐ Formula _____

Feedings: Amount _____ Frequency _____

☐ Newborn Hearing Screening Results

☐ Review Immunization Record

☐ WIC Referral

Elimination:_____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Family Planning	☐ No Bottle in Bed
☐ Development	☐ Sleeping on Back
☐ Infant Bond	☐ Shaken Baby Syndrome
☐ Passive Smoke	☐ Fever Protocols
☐ Appropriate Car Seat	☐ Child Care Issues
☐ Safety (general)	☐ Oral Health Care
☐ Crib Safety	☐ Honey Restrictions
☐ Feeding/Colic	

Other: _____

Assessment:

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

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

NEXT VISIT: 4 MONTHS OF AGE

Health Provider Signature: