

PEDIATRIC VISIT 9 to 11 MONTHS

DATE OF SERVICE _____

NAME _____ M / F DATE OF BIRTH _____ AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ % HC _____ / _____ % TEMP _____

HISTORY:

Family health history documented & updated? _____

Perinatal history documented & 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: TB (Annual) LEAD

(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION:

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Face
<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Red reflex/Cover test
<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Dentition (# of teeth)
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	Genitals
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Extremities/Hips/Feet
<input type="checkbox"/>	<input type="checkbox"/>	Neuro/Reflexes/Tone
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision (gross assessment)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:

Breast/bottle: Amount & frequency _____

Bowel/bladder: Number of wet____, dry____ in 24 hours?

Number BM's in 24 hours? _____

Education: Jar/table foods Offer cup Avoid small hard foods
Encourage self-feeding/finger foods Expect messiness/playing with food Water only bedtime bottle

DEVELOPMENTAL SCREENING: (With Standardized Tool) REQUIRED

ASQ: PEDs Other: (specify) _____

Results: Wnl Areas of Concern: _____

Referred: Yes / No Where? _____

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Shy with strangers Plays patty cake

Looks for fallen object

Fine Motor: Bangs two cubes Pincer grasp Reaches, grabs Feeds self Drinks from cup

Language: Dada or Mama (specific) Babbles

Imitates speech sounds

Gross Motor: Gets to sitting Pulls self to stand

ANTICIPATORY GUIDANCE: (Check all that were discussed)

Social: Fear of strangers Separation anxiety

Parenting: Emphasize protection over discipline

Temper tantrums: ignore, distract May need reassurance for separation anxiety

Play and communication: Water and sand play Toys with moving parts, holes, strings to pull Beginning speech sounds

Health: Fluoride if well water Second hand smoke

Clean teeth with soft toothbrush or cloth Use sunscreen

Injury prevention: Rear riding/rear facing infant car seat

Smoke detector/escape plan Poison control#

Hot liquids Hot water set at 120° Water safety (tub, pool)

Choking/suffocation Firearms (owner risk/safe storage)

Fall prevention (heights) Baby proof home

Don't leave unattended

PLANS/ORDERS/REFERRALS

1. Immunizations ordered _____
2. Lead test referral (if positive risk assessment) _____
3. Fluoride Varnish Applied? Yes / No _____
4. Next preventive appointment at 12 months _____
5. Referrals for identified problems? (specify) _____

Signatures: _____