

# WELL CHILD EXAM EARLY CHILDHOOD: 9 MONTHS

Authority: P.A. 116 of 1973  
Completion: Required  
Consequences of non-completion:  
Non-compliance of licensing rules.

Michigan Department of Human Services

Well Child Exam Date		Patient Name		DOB	Sex	Parent Name				
Allergies					Current Medications					
Prenatal/Family History										
Weight	Percentile %	Length	Percentile %	Wt. for length Percentile %	HC	Percentile %	Temp.	Pulse	Resp.	BP (if risk)

  

<p><b>Interval History:</b> (Include injury/illness, visits to other health care providers, changes in family or home)</p> <p><b>Nutrition</b></p> <p><input type="checkbox"/> Breast every _____ hours</p> <p><input type="checkbox"/> Formula _____ oz every _____ hrs. With iron <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type or brand _____</p> <p><input type="checkbox"/> City water <input type="checkbox"/> Well water Solids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Elimination</b></p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p><b>Sleep</b></p> <p><input type="checkbox"/> Normal (8–10 hrs at night) <input type="checkbox"/> Abnormal</p> <p>Additional area for comments on page 2</p> <p><b>WIC</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Maternal Infant Health Program</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Screening and Procedures</b></p> <p><input type="checkbox"/> Oral Health Risk Assessment</p> <p><input type="checkbox"/> Subjective Hearing – Parental observation/ concerns</p> <p><input type="checkbox"/> Subjective Vision – Parental observation/ concerns</p> <p><b>Standardized Developmental Screening</b></p> <p><input type="checkbox"/> Completed Tool Used _____</p> <p>RESULTS: <input type="checkbox"/> No Risk <input type="checkbox"/> At Risk</p> <p><b>Psychosocial/Behavioral Assessment</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Screening for Abuse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Screen If At Risk</b></p> <p><input type="checkbox"/> Lead level _____ mcg/dl</p> <p><b>Immunizations:</b></p> <p><input type="checkbox"/> Immunizations Reviewed</p> <p><input type="checkbox"/> Immunizations Given &amp; Charted – <i>if not given, document rationale</i></p> <p><input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB <input type="checkbox"/> Hib</p> <p><input type="checkbox"/> PCV <input type="checkbox"/> Rota <input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> MCIR checked/updated</p> <p><input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours</p>	<p>Patient Unclothed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">Review of Systems</th> <th colspan="2">Physical Exam</th> <th rowspan="2">Systems</th> </tr> <tr> <th>N</th> <th>A</th> <th>N</th> <th>A</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Appearance</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Skin/nodes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Head/fontanel</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eyes</td></tr> <tr><td><input 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<p>If yes, see additional note area on next page</p> <p>Results of visit discussed with parent</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Plan</b></p> <p><input type="checkbox"/> History/Problem List/Meds Updated</p> <p><input type="checkbox"/> Referrals</p> <p><input type="checkbox"/> WIC <input type="checkbox"/> Early On <input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> Maternal Infant Health Program (MIHP)</p> <p><input type="checkbox"/> Children Special Health Care Needs</p> <p><input type="checkbox"/> Other referral _____</p> <p><input type="checkbox"/> Other _____</p>	Review of Systems	Physical Exam		Systems	N	A	N	A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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type="checkbox"/> Limit time in sun/use hat and sunscreen</p> <p><input type="checkbox"/> Check home for lead poisoning hazards</p> <p><b>Nutrition</b></p> <p><input type="checkbox"/> Breastfeed or give iron-fortified formula</p> <p><input type="checkbox"/> Encourage self-feeding, cup use</p> <p><input type="checkbox"/> 3 meals and 2-3 snacks w/variety of foods</p> <p><input type="checkbox"/> Avoid foods that contribute to allergies</p> <p><input type="checkbox"/> Increase soft, moist table foods gradually</p> <p><b>Infant Development</b></p> <p><input type="checkbox"/> Talk, sing, play games and read to baby</p> <p><input type="checkbox"/> Consistent daily/bedtime routine</p> <p><input type="checkbox"/> Changing sleep patterns</p> <p><input type="checkbox"/> Safe exploration opportunities</p> <p><input type="checkbox"/> Play Pat a Cake, Peek a Boo, So Big</p> <p><input type="checkbox"/> Crib Safety/lower mattress</p> <p><input type="checkbox"/> Avoid TV, videos, computers</p> <p><b>Family Support and Relationships</b></p> <p><input type="checkbox"/> Make time for self, partner, friends</p> <p><input type="checkbox"/> Set examples and use simple word to discipline – don't yell at, hit or shake baby</p> <p><input type="checkbox"/> Use consistent positive discipline</p> <p><input type="checkbox"/> Discuss baby's explorations w/siblings</p> <p><input type="checkbox"/> Choose responsible caregivers</p> <p><input type="checkbox"/> Substance Abuse, Child Abuse, Domestic Violence Prevention, Depression</p> <p>Other Anticipatory Guidance Discussed:</p> <p style="text-align: center;">Next Well Check: 12 months of age</p> <p>A standardized developmental screening tool to be administered – see page 2.</p> <p style="text-align: center;">Page 3 required for Foster Care Children</p> <p>Medical Provider Signature:</p>
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**PAGE 2 – WELL CHILD EXAM – INFANCY: 9 Months – Developmental Screening**

A standardized developmental screening tool should be administered (Medicaid required and AAP recommended) at the 9 month visit. Please record findings on this page.

Date	Child's Name	DOB
Name of person who accompanied child to appointment	<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent	
Phone number of person who accompanied child to appointment	<input type="checkbox"/> Relative Caregiver (specify relationship) <input type="checkbox"/> Caseworker	

**Developmental, Social/Emotional and Behavioral Health Screenings**

Always ask parents or guardian if they have concerns about development or behavior. (You must use a standardized developmental instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening completed: Date \_\_\_\_\_

Screener Used:  ASQ  ASQSE  PEDS  PEDSDM  Other tool: \_\_\_\_\_ Score: \_\_\_\_\_

Referral Needed:  No  Yes Agency: \_\_\_\_\_

Referral Made:  No  Yes Date of Referral: \_\_\_\_\_ Agency: \_\_\_\_\_

Current or Past Mental Health Services Received:  No  Yes (if yes please provide name of provider)

Name of Mental Health Provider: \_\_\_\_\_

Additional Notes from pages 1 and 2:

Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.):

Signature of staff who gave/scored screener if applicable
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**THIS PAGE IS REQUIRED FRO FOSTER CARE CHILDRE  
PAGE 3 – WELL CHILD EXAM – INFANCY: 9 Months**

A standardized developmental screening tool should be administered (Medicaid required and AAP recommended) at the 9 month visit. Please record findings on this page.

Date	Child's Name	DOB
Name of person who accompanied child to appointment	<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent	
Phone number of person who accompanied child to appointment	<input type="checkbox"/> Relative Caregiver (specify relationship) <input type="checkbox"/> Caseworker	

**Physical completed utilizing all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements**

- Yes Please attach completed physical form utilized at this visit
- No If no, please state reason physical exam was not completed \_\_\_\_\_

**Developmental, Social/Emotional and Behavioral Health Screenings**

Always ask parents or guardian if they have concerns about development or behavior. (You must use a standardized developmental instrument or screening tool as required by the Michigan Department of Community Health and Michigan Department of Human Services).

Validated Standardized Developmental Screening completed: Date \_\_\_\_\_

Screener Used:  ASQ  ASQSE  PEDS  PEDSDM  Other tool: \_\_\_\_\_ Score: \_\_\_\_\_

Referral Needed:  No  Yes Agency: \_\_\_\_\_

Referral Made:  No  Yes Date of Referral: \_\_\_\_\_ Agency: \_\_\_\_\_

Current or Past Mental Health Services Received:  No  Yes (if yes please provide name of provider)

Name of Mental Health Provider: \_\_\_\_\_

**EPSDT Abnormal results:**

**Special Needs for Child (e.g., DME, therapy, special diet, school accommodations, activity restrictions, etc.):**

Medical Provider Signature	Medical Provider Name (please print)
Address	Telephone Number

This form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Department of Human Services, Michigan Association of Health Plans, and Michigan Association of Local Public Health.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

## FOSTER PARENT/CAREGIVER HANDOUT

### Your Child's Health at 9 Months

#### Milestones

Ways your baby is developing between 9 and 12 months of age.

- Pulls self up and moves holding onto furniture
- May start walking
- Points at things she wants
- Drinks from a cup and feeds himself
- Plays games such as Pt-a-Cake and Peek-a-Boo
- Says 1-3 words, (besides "mama," "dada")
- Enjoys books
- Seeks parent for reassurance
- Picks things up with thumb and one finger
- Is able to be happy, mad and sad

#### For Help or More Information:

##### Breastfeeding, food and health information:

- Women, Infant, and Children (WIC) Program, call 1-800-26-BIRTH.
- The National Women's Health Information Center Breastfeeding Helpline. Call 1-800-994-9662, or visit the website at: [www.womenshealth.gov/breastfeeding](http://www.womenshealth.gov/breastfeeding)
- LA LECHE League – 1-800-LALECHE (525-3243). Visit the website at: <http://www.lalecheleague.org>
- Text4Baby for health and development information – <http://www.text4baby.org/>

##### Care seat safety:

- Contact the Auto Safety Hotline at 1-888-327-4236 or online at [www.safercar.gov](http://www.safercar.gov)
- To locate a Child Safety Seat Inspection Station, call 1-866-SEATCHECK (866-732-8243) or online at [www.seatcheck.org](http://www.seatcheck.org)

##### For information about lead screening:

Visit the Michigan Bridges 4 Kids lead website at [www.bridges4kids.org/lead.html](http://www.bridges4kids.org/lead.html) or contact the Childhood Lead Poisoning Prevention Project at (517) 335-8885

##### Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or [www.usa.safekids.org/](http://www.usa.safekids.org/)

##### For information if you're concerned about your child's development:

Contact Early On Michigan at 1-800-327-5966 or Project Find at <http://www.projectfindmichigan.org/> or call 1-800-252-0052

##### For information about childhood immunizations:

Call the National Immunization Program Hotline at 1-800-232-4636 or online at <http://www.cdc.gov/vaccines>

##### Domestic Violence hotline:

National Domestic Violence Hotline – (800) 799-SAFE (7233) or online at [www.ndvh.org](http://www.ndvh.org)

## Health Tips

Wash your hands often; especially after diaper changes and before you feed your baby. Wash your baby's toys with soap and water.

Slowly add foods that feel different to your baby. Foods that are crushed, blended, mashed, small chopped pieces, and soft lumps – foods like mashed vegetables or cooked pasta.

Let your baby drink some water, breast milk, or formula from a cup.

Keep soft bedding and stuffed toys out of the crib. Make sure your baby sleeps by herself in crib or portable crib.

Keep your baby's new teeth healthy. Clean them after feedings. Use the corner of a clean cloth or a tiny, soft toothbrush. Don't let your baby take a bottle to bed.

#### Parenting Tips:

Read to your baby. Show your baby picture books and talk about the pictures. Sing songs and say nursery rhymes

Make your home safe and encourage your baby to explore.

Babies develop in their own way. Your baby should keep learning and changing. If you think he is not developing well, talk to your doctor or nurse.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1-800-942-4357 (in Michigan). They will not ask your name and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

#### Safety Tips

Always watch your baby in the bathtub. Drowning can happen quickly and silently in only a few inches of water. Take your baby with you if you have to leave the room.

Poison Control Center: 1-800-222-1222

Buckle up your baby in a car seat facing the rear of the car for the first year. Keep your baby in the back seat. It's the safest place for children to ride.

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