Optimum Internal Medicine and Pediatrics

10044 Hwy 46, Bon Aqua, TN 37025 | (931) 996-4247

2 Month Visit

Parent and staff instructions - keep with the clinical sheet

Parents / guardians: Complete only the identification, allergies, medicines, and the upper-left Nutrition and Problems / Interval History sections. You may type in the available identification fields, then print. Leave measurements, risk-assessment results, screening scores, examinations, orders, vaccine entries, billing and signatures for staff. Bring **both pages** to the appointment. Do not send completed forms through the website.

Do not give medicine based on this form alone. Printed doses and vaccine sequence numbers on the clinical sheet are preserved workflow entries, not patient-specific orders.

Staff medication verification: Before any dose, verify current weight in kg, age, indication, allergies, product concentration, dose in mg **and** mL, interval, maximum daily dose and contraindications. Document clinician-approved instructions. Preserved numbers do not replace this check.

Age-specific clinical checks

Young-infant fever: A temperature of 100.4 F (38 C) or higher requires immediate clinician contact; do not delay evaluation to give fever medicine.

Vitamin D: confirm total intake. Infants who are breastfed or partly breastfed, and formula-fed infants taking less than 32 oz/day, generally need 400 IU/day. Complementary foods begin around 6 months when ready, not before 4 months.

Rotavirus: first dose no later than 14 weeks 6 days; last dose no later than 8 months 0 days. PCV15 or PCV20 is used for the routine infant series; reconcile prior products and doses.

RSV: verify age, season, prior antibody and maternal vaccination **in this pregnancy**. Use current AAP 2026-27 criteria: nirsevimab or clesrovimab for eligible infants under 8 months; nirsevimab only for eligible high-risk children 8-19 months entering their second season.

Staff screening check: Use validated age-appropriate tools, not checkboxes alone: developmental screens at 9, 18 and 30 months; autism at 18 and 24 months; mental/emotional/behavioral screening per current AAP schedule.

Staff vaccine and billing check: Reconcile actual records, age, product, prior doses, minimum intervals and contraindications against current AAP guidance. Verify preserved protocol numbers, including combination-vaccine components. Billing presets are not orders: code actual services and payer rules; COVID-19 administration uses 90480, not 90460/90472. Do not automatically apply modifiers or unit counts.

Sources and version

Clinic revision based on AAP 2026 immunization guidance, current AAP preventive-care guidance and age-specific safety references. Original TNAAP 07/2025 attribution and intentional workflow marks are retained. This clinic revision does not imply TNAAP endorsement.

AAP preventive care | AAP 2026 immunizations | AAP current RSV guidance

Two Month Visit

Date _____

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Tennessee Chapter
INCORPORATED IN TENNESSEE
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Form revised 07/2025

Name _____ Birth Date _____ Age _____

Historian _____ Allergies _____ Medications _____

Weight _____kgs. Length _____cm W/L _____%tile Head circ. _____cm Temp. _____AX REC

B/P if indicated _____ / _____

Nutrition
☐ Breast _____min. q._____ hrs.
☐ Formula _____oz. q. _____ hrs.
Brand _____
Water: ☐ city ☐ well ☐ spring ☐ bottled
WIC ☐ Yes ☐ No

Interval History/New Problems
Change in family history? ☐ Yes ☐ No
Change in social history? ☐ Yes ☐ No
If Yes, what? _____
_____
Are there new problems or illnesses since the last visit? ☐ Yes ☐ No
If Yes, what? _____
_____

Constipation	☐ Yes	☐ No
Sleep	☐ Yes	☐ No
Spitting up	☐ Yes	☐ No
Stuffy nose	☐ Yes	☐ No
Colic	☐ Yes	☐ No
Diaper rash	☐ Yes	☐ No

Other Problems: _____
_____
_____

Hearing Risk Assessment

Responds to sounds	☐ Yes	☐ No
Smiles and laughs	☐ Yes	☐ No

Newborn hearing screen:
☐ Passed ☐ Repeat scheduled ☐ Not done

Vision Risk Assessment

Looks at parent's face	☐ Yes	☐ No
Follows with eyes	☐ Yes	☐ No

Newborn Metabolic/Hemoglobinopathy Screening:
☐ **Normal** ☐ **Repeat** ☐ **Pending**

Hepatitis B Risk Assessment
☐ Yes ☐ No

Developmental Surveillance
☐ Yes ☐ No Concerns?_____

Psychosocial/Behavioral Surveillance
☐ Yes ☐ No Concerns? _____

Maternal Postpartum Depression Screen — +

Physical Exam

Undressed: ☒ yes ☐ no

General	☐ nl	☐ abnl
Head	☐ nl	☐ abnl
Fontanel	☐ nl	☐ abnl
Neck	☐ nl	☐ abnl
Eyes	☐ nl	☐ abnl
Red reflex	☐ nl	☐ abnl
Alignment	☐ nl	☐ abnl
Ears	☐ nl	☐ abnl
Nose	☐ nl	☐ abnl
Throat/Mouth	☐ nl	☐ abnl
Lungs	☐ nl	☐ abnl
Heart	☐ nl	☐ abnl
Abdomen	☐ nl	☐ abnl
Femoral Pulses	☐ nl	☐ abnl
Spine	☐ nl	☐ abnl
Extremities	☐ nl	☐ abnl
Hips	☐ nl	☐ abnl
Skin	☐ nl	☐ abnl
Neuro	☐ nl	☐ abnl
Genitalia		
Female	☐ nl	☐ abnl
Male	☐ nl	☐ abnl
Testes	☐ nl	☐ abnl

EPSDT CPT Coding/ICD10: 99381-25 if New or 99391-25 Est Z00.129 Normal or Z00.121 Abnormal
90460-59, 4 units if option 1or 2 or 3 units if option 3 chosen Z23 90461-59, 4 units if option 1 or 2 chosen or 5 units if option 3 chosen Z23
96110-59 Z13.40
96161-59 Z13.32
Vaccine codes as marked
Add E/M code if abnormal findings requiring treatment with -25 modifier

Plan for Mother based on PP screening results:_____

RSV mAb during RSV Season if Mother not vaccinated and avail.
Vaxelis #1 (DTap, IPV, Hib, Hep B)
Prevnar 20 #1 (Pneumo #1)
Rotavirus #1

[**Rotateq** (2,4,6 mos.) or **Rotarix** (2, 4 mos.) *]
*First dose: max 14wk6d and last dose: max 8mo0d of age

Safety
☐Car seat, facing backwards
☐Smoke free environment
☐Smoke detectors in home
☐Hot water < 120 degrees
☐No bottle propping
☐Safe sleep/sleep on back
☐Crib safety
☐Rolling over, prevent falls

Health
☐If bottle fed, per hunger and growth☐If breast fed, nurses 8-10 times/day☐ Delay solids
☐Bowel movements
☐Strong urinary stream if male
☐Fever
☐No Honey

Social/Behavioral
☐Temperment
☐Sleep
☐Talk to baby
☐Support for mother

Impression
☐Well Newborn
☐Normal Growth
☐Normal Development
☐ _____
☐ _____

Plan/Referrals
☒Immunizations current? ☒ Yes ☐ No☐ Influenza/TdaP for caregivers
☐Hep B, Rotavirus, DTaP, Hib, PCV , IPV☐Counseling
☒Acetaminophen____80____mg. q. 4-6 hrs.
☐Vitamin D if indicated 400 IU/D
☒Two month Handout sheet
☒RTC at 4 months
☐Parent declination of treatment _____
☐Referrals _____
☐ _____
☐ _____

_____ M.D. / P.N.P. / DO / PA