

# Canadian Family Medicine Clinical Card

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## 2 - 6 Months

2 months visit	4 months visit	6 months visit
Use WHO growth charts Length, wt, HC	Use WHO growth charts Length, wt, HC	Use WHO growth charts Length, wt, HC
<b>CAREGIVER CONCERNS:</b>		
Record concerns at each visit		
<b>NUTRITION:</b>		
Addressed each visit:	<input type="checkbox"/> <b>Breastfeeding?</b> + Vit D 400 IU/day <input type="checkbox"/> <i>Formula feeding/preparation</i>	
<input type="checkbox"/> Formula amount: 600-900 mL/day	<input type="checkbox"/> Formula amount: 750-1080 mL/day <input type="checkbox"/> Discuss future introduction of solids with emphasis on iron containing and allergenic foods	<input type="checkbox"/> Formula amount: 750-1080 mL/day <input type="checkbox"/> <b>Iron-containing foods</b> <input type="checkbox"/> Allergenic foods <input type="checkbox"/> Fruits, veggies, dairy <input type="checkbox"/> No honey <input type="checkbox"/> Choking/safe foods <input type="checkbox"/> Avoid food/liquids high in sugar or salt <input type="checkbox"/> No bottles in bed
<b>EDUCATION &amp; ADVICE: Repeat discussion based on risk or need</b>		
<b>Injury Prevention:</b>		
<input type="checkbox"/> Safe sleep (position, room sharing, no bed sharing, crib safety) <input type="checkbox"/> Motorized vehicle safety/car seat	<input type="checkbox"/> Hot water <49 C/ bath safety <input type="checkbox"/> Pacifier use <input type="checkbox"/> Choking/safe toys <input type="checkbox"/> Falls	<input type="checkbox"/> Electric plugs/ cords <input type="checkbox"/> Firearm safety <input type="checkbox"/> Smoke/CO detectors <input type="checkbox"/> Poisons: PCC#
<b>Behaviour &amp; Family Issues:</b>		
<input type="checkbox"/> Parental fatigue/ post partum depression <input type="checkbox"/> Family healthy active living/ sedentary behaviour/ screen time <input type="checkbox"/> Encourage reading	<input type="checkbox"/> Healthy sleep habits <input type="checkbox"/> Soothability /responsiveness <input type="checkbox"/> Night waking <input type="checkbox"/> Crying <input type="checkbox"/> Parenting/bonding <input type="checkbox"/> Siblings	<input type="checkbox"/> Poverty/food insecurity <input type="checkbox"/> High risk infants/ home visit need <input type="checkbox"/> Family conflict/ stress <input type="checkbox"/> Child care/return to work

2 months visit	4 months visit	6 months visit
<b>EDUCATION &amp; ADVICE - Continued</b>		
<b>Environment:</b>		
<input type="checkbox"/> Second hand smoke/E-cigs/Cannabis <input type="checkbox"/> Sun exposure <input type="checkbox"/> Insect repellent/pesticides		
<b>Other Issues:</b>		
<input type="checkbox"/> Teething/Dental cleaning/fluoride <input type="checkbox"/> Supervised tummy time while awake	<input type="checkbox"/> No OTC cough/cold meds <input type="checkbox"/> Fever advice/thermometers <input type="checkbox"/> Complementary/ alternative meds?	<input type="checkbox"/> Temp control/overdressing <input type="checkbox"/> Encourage reading
<b>DEVELOPMENT: Failure to meet an item is a red flag for development</b>		
<input type="checkbox"/> Follows movt with eyes <input type="checkbox"/> Coos <input type="checkbox"/> Lifts head while on tummy <input type="checkbox"/> Comforted/calmed by touching/rocking <input type="checkbox"/> ≥2 sucks before swallowing/breathing <input type="checkbox"/> Smiles responsively <input type="checkbox"/> No concerns	<input type="checkbox"/> Follows moving toy or person with eyes <input type="checkbox"/> Responds to people with excitement <input type="checkbox"/> Holds head steady when sitting <input type="checkbox"/> Holds an object briefly <input type="checkbox"/> Laughs/smiles responsively <input type="checkbox"/> No concerns	<input type="checkbox"/> Turns head toward sounds <input type="checkbox"/> Makes sounds while you talk to them <input type="checkbox"/> Vocalizes pleasure & displeasure <input type="checkbox"/> Rolls from back to side <input type="checkbox"/> Sits with support <input type="checkbox"/> Reaches/grasps w both hands equally <input type="checkbox"/> No persistent closed hands/fists <input type="checkbox"/> No concerns
<b>PHYSICAL EXAM:</b>		
<input type="checkbox"/> Fontanelles <input type="checkbox"/> Skin (jaundice)	<input type="checkbox"/> Anterior fontanelle	<input type="checkbox"/> Anterior fontanelle <input type="checkbox"/> Cover-uncover test <input type="checkbox"/> Teeth/Caries risk assess. <input type="checkbox"/> No head lag
<b>Each visit:</b>		
<input type="checkbox"/> Eyes (red reflex) <input type="checkbox"/> Corneal light reflex <input type="checkbox"/> Bruising	<input type="checkbox"/> Hips <input type="checkbox"/> Neck-torticollis <input type="checkbox"/> Muscle tone	<input type="checkbox"/> Hearing inquiry/ screening <input type="checkbox"/> Heart/lungs/abdomen
<b>PROBLEMS &amp; PLANS/CURRENT &amp; NEW REFERRALS: Record at each visit</b>		
<b>INVESTIGATIONS/IMMUNIZATIONS: Record vaccines, discuss pain reduction</b>		
<b>6 month visit:</b>		
<input type="checkbox"/> If HBsAG+ parent/ sibling, Hep B vaccine #3 <input type="checkbox"/> Anemia screening (if at risk) <input type="checkbox"/> Risk factors for TB?		