The Arizona Health Care Cost Containment System (AHCCCS) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Clinical Sample Templates may be used by all providers offering care to AHCCCS members under 21 years of age to document age-specific, information related to EPSDT screenings and visits. The Providers may choose to utilize an AHCCCS EPSDT Clinical Sample Template, or an equivalent form approved by the contracted health plan, so long as the form includes all components present on the AHCCCS EPSDT Clinical Sample Templates. These components include, but are not limited to:

1. Documentation of comprehensive physical exam (including appropriate weights and vital signs),
2. Age-appropriate screenings (vision, hearing, oral health, nutrition, developmental, nutritional, Tuberculosis [TB] and lead),
3. Developmental surveillance,
4. Anticipatory guidance (Age-Appropriate Education and Guidance),
5. Social-emotional health (Behavioral Health) surveillance,
6. Age-appropriate labs and immunizations, and
7. Medically necessary referrals including those to the member’s dental home starting at 6 months of age, or sooner as needed, for routine biannual examinations.

Refer to AMPM Chapter 400 for EPSDT responsibilities and services.

**NOTE: The Centers for Medicare and Medicaid Services (CMS) require AHCCCS to provide specified services to our EPSDT population. These EPSDT Clinical Sample Templates have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care.**

**Providers: Please do not send hard copies of EPSDT Clinical Sample Templates to the AHCCCS office. Contact your contracted health plan for instructions on how to submit forms directly to the plan.**

**Three to Five Days Old AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Temp:** | **Pulse:** | **Resp:** |
| ** Yes** | ** No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Hospital Newborn Hearing Screen:**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. Ear**  Pass  Refer  Unknown**Second Newborn Hearing Screen (If 2ndNeeded/Completed):**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. Ear**  Pass  Refer  Unknown |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **ORAL HEALTH:**  Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed) |
| **NUTRITIONAL SCREENING:**  BreastfeedingFrequency/Duration:  Supplements:  Vit D FormulaType: Amount/Duration: AdequateWeightGain Yes  No  ReceivingWICServices |
| **DEVELOPMENTAL SURVEILLANCE:**  Rooting Reflex  Startle  Suck & Swallow  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking PreventionCar/Car Seat Safety (Rear-Facing)  Safe Sleep  Shaken Baby Prevention  Safe Bathing/Water TemperaturePassive Smoke  Safety at Home/Child-Proofing  Sun Safety  Pacifier Use  Bottle Propping  Infant BondingSupport Systems/Resources  Infant Crying/Appropriate Interventions  Other:  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child Appropriate Bonding/Responsive to Needs  Infant Hands to Mouth/Self-Calming  Postpartum Depression Screen  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** | 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit)  Other  |
| **IMMUNIZATIONS ORDERED:** | **DATE 1ST HEP B ADMINISTERED:**  Hep B (Not Previously Administered)  Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  2nd Newborn Hearing Screen (If Needed) |
| **PROVIDER’S SIGNATURE:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**One Month Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Temp:** | **Pulse:** | **Resp:** |
| **Yes** | **No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Hospital Newborn Hearing Screen:**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. ear**  Pass  Refer  Unknown**Second Newborn Hearing Screen (If 2nd Needed/Completed):**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. Ear**  Pass  Refer  Unknown |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **ORAL HEALTH:**  Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed) |
| **NUTRITIONAL SCREENING:**  BreastfeedingFrequency/Duration:  Supplements:  Vit DFormulaType: Amount/Duration: Adequate Weight Gain Yes  No  Receiving WIC Services |
| **DEVELOPMENTAL SURVEILLANCE:**  Responds to Sounds  Responds to Parent’s Voice  Follows With Eyes to MidlineAwake For 1 Hour Stretches  Beginning Tummy Time https://www.cdc.gov/ncbddd/actearly/milestones/index.html  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety Drowning Prevention  Choking PreventionCar/Car Seat Safety (Rear-Facing)  Safe Sleep  Shaken Baby Prevention  Safe Bathing/Water TemperaturePassive Smoke  Safety at Home/Child-Proofing  Sun Safety  Pacifier Use  Bottle Propping  Infant BondingSupport Systems/Resources  Infant Crying/Appropriate Interventions  Other:  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to ChildInfant Hands to Mouth/Self -Calming  Appropriate Bonding/Responsive to Needs  Postpartum Depression Screen Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** | 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit)  Other Results of 2nd AZ Newborn Screening Received (If No, What Follow Up Taken: ) |
| **IMMUNIZATIONS ORDERED:** | DATE1stHEPB/2ndHEPB ADMINISTERED**: /**  Hep B (Not Previously Administered)  Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  2nd Newborn Hearing Screen (If needed) |
| **PROVIDER’S SIGNATURE:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Two Months Old -AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Temp:** | **Pulse:** | **Resp:** |
| **Yes** | **No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Risk Indicators of Hearing Loss:**  Yes  No**Hospital Newborn Hearing Screen:**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. Ear**  Pass  Refer  Unknown**Second Newborn Hearing Screen (If 2nd Needed/Completed):**  ABR  OAE: **Rt. Ear**  Pass  Refer **Lt. Ear**  Pass  Refer  Unknown |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **ORAL HEALTH:**  Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed) |
| **NUTRITIONAL SCREENING:**  Breastfeeding Frequency/Duration:  Supplements:  Vit DFormulaType: Amount/Duration: Adequate Weight Gain Yes  No  Receiving WIC Services |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2mo.html Some Head Control  Tummy Time/Lifts Head, Neck with Forearm Support  Social SmileCoos  Begins Imitation of Movement and Facial Expressions  Makes Eye Contact  Fixes/Follows with Eyes to MidlineStartles At Loud Noises  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking PreventionCar/Car Seat Safety (Rear-Facing)  Safe Sleep  Shaken Baby Prevention  Safe Bathing/Water Temperature  Passive SmokeSafety at Home/Child-Proofing  Sun Safety  Pacifier Use  Bottle Propping  Infant Bonding  Support Systems/ResourcesInfant Crying/Appropriate Interventions  Parent Reads to Child  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to ChildAppropriate Bonding/Responsive to Needs  Infant Hands to Mouth/Self-Calming  Enjoys Interacting with OthersPostpartumDepressionScreen  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** | 2nd Arizona Newborn Screening Bloodspot Test (If Needed)  Other Results of 2nd AZ Newborn Screening Received (If No, What Follow Up Taken: ) |
| **IMMUNIZATIONS ORDERED:** | HepB  DTaP  Hib  IPV  PCV  Rotavirus  Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  |
| **PROVIDER’S SIGNATURE:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Four Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
| **Yes** | **No** | **Yes** | **No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **ORAL HEALTH:**  Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed) |
| **NUTRITIONAL SCREENING:**  BreastfeedingFrequency/Duration:  Supplements:  Vit DFormula Type: Amount/Duration: Adequate Weight Gain Yes  No  Receiving WIC ServicesCereal Type:  Plan to Introduce Solids  Soda/Juice |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4mo.html  Babbles and Coos  Laughs  Begins to Roll Front to Back  Pushes Up with ArmsControls Head Well  Reaches for Objects  Interest in Mirror Images  Pushes Down with Legs When Feet on SurfaceAppropriate Eye Contact  Tummy Time  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking PreventionCar/Car Seat Safety (Rear-Facing)  Safe Sleep  Shaken Baby Prevention  Safe Bathing/Water TemperaturePassive Smoke  Safety at Home/Child-Proofing  Sun Safety  Bottle Propping  Support Systems/ResourcesInfant Crying/Appropriate Interventions  Discuss Child Temperament  Establish Daily Routines/Infant RegulationEstablish Nighttime Sleep Routine/Sleep Through Night (Greater 5 hours)  Parent Reads to Child  Other  |
| **SOCIAL-EMOTIONAL HEALTH AND (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to BabyInfant Hands to Mouth/Self-Calming  Smiles When Hears Parents’ Voices  Appropriate Bonding/Responsive to NeedsEasily Distracted/Excited by Discovery of Outside World  Postpartum Depression Screen   Other  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  Other  |
| **IMMUNIZATIONS ORDERED:** |  HepB  DTaP  Hib  IPV  PCV  Rotavirus  Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS   Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |   ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:   Developmental  Behavioral  Other   |
| **PROVIDER’S SIGNATURE:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

**Six Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
|  **Yes** |  **No** |  **Yes** |  **No** |  |  |  |
| **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code  Yes  No |
| **ORAL HEALTH:**  Parent Cleaning Baby’s Gums with Washcloth/Infant Toothbrush  Fluoride Supplement  FluorideVarnishbyPCP (Every 3 months) |
| **NUTRITIONAL SCREENING:**  BreastfeedingFrequency/Duration:  Supplements:  Vit DFormulaType: Amount/Duration: Adequate Weight Gain Yes  No Receiving WIC ServicesCereal Type:  Plan to Introduce Solids  Soda/Juice |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-6mo.html  Using A String of Vowels  Rolls Over  Transfers Small Objects  Vocal Imitation Sits with Support  Explores with Hands and Mouth  Peek-a-Boo/Patty Cake  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking PreventionCar/Car Seat Safety (Rear-Facing)  Safe Sleep  Shaken Baby Prevention  Passive Smoke  Safety at Home/ChildproofingSun Safety  Refrain from Jump Seat/Walker  Sleep**/**Wake Cycle  Introduce Cup  Begin Using HighchairWary of Strangers  Introduce Board Books  Parent Reads to Child  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Baby Appropriate Bonding/Responsive to Needs  Recognizes Familiar People  Distinguishes Emotions by Tone of VoiceSelf-Calming  Enjoys Social Play  PostpartumDepressionScreen  other  Other  |

U **COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

U **ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting(Child at Risk)  Finger Stick (Result: )  Venous  Other  |
| **IMMUNIZATIONS ORDERED:** | HepB  DTaP  Hib  IPV  PCV  Influenza  Rotavirus  Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason:Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other   |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Nine Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
| **Yes** | **No** | **Yes** | **No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **DEVELOPMENTAL SCREENING TOOL COMPLETED:**  ASQ PEDS |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code  Yes  No |
|  **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Parent Cleaning Baby’s Gums with Infant ToothbrushFluoride Supplement FluorideVarnishbyPCP(every 3 months) |
| **NUTRITIONAL SCREENING:**  Breastfeeding FormulaAmount:  Supplements:  Vit D  ReceivingWICServices **Adequate Weight Gain**  Yes  No Plan to Introduce Table Foods  Drinks from Cup  Soda/Juice |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-9mo.html  Sits Independently   Pulls to Stand/Cruising  Plays Peek-A-Boo  Uses Words “Mama/Dada”Waves Bye-Bye  Wary of Strangers  Immature Pincer  Repeats Sounds/Gestures for Attention  Explores Environment  Other https://www.cdc.gov/ncbddd/actearly/milestones/milestones-6mo.html |
| **ANTICIPATORY GUIDANCE PROVIDED:** Emergency/911  Gun Safety  Drowning Prevention  Safe Sleep  Shaken Baby Prevention Choking Prevention/Soft Texture Finger Foods  Car/Car Seat Safety (Rear-Facing) Passive Smoke  Sun Safety  Safety at Home/Child-Proofing  Sleep/Wake Cycle  TV Screen Time  Exploration/Learning Redirection/Positive Parent Language/Read to Child/Introduce Board Books  Follow Child’s Lead in Play Parent Communicates to Child “What Things Are” (Ball, Cat, Etc.)  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to ChildAppropriate Bonding/Responsive to Needs  Self-Calming  Growing Independence  Shows Preference for Certain People/ToysCries When Primary Caregiver Leaves  Postpartum Depression  Other:  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** |   BloodLeadTesting(Child at Risk)  Finger Stick (Result: )  Venous  Hgb/Hct  Other |
| **IMMUNIZATIONS ORDERED:** |  HepB  DTaP  Hib  IPV  PCV  Influenza  Other  Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason:  Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |  ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**12 Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
|  **Yes** |  **No** |  **Yes** |  **No** |  |  |  |
|  **Allergies:** | **Birth Weight:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Vision Screening:** | **Corrected:**  **Yes**  **No** | **Automated Device**  | **Right:** **Pass**  **Refer** | **Left:** **Pass**  **Refer** | **Both:** **Pass**  **Refer** |  **Unable to Perform** |

 **FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
|  **BLOOD LEAD LEVEL REQUIRED** (see below) |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice by Parent)  Fluoride Supplement FluorideVarnishbyPCP(Every 3 months)First Dental Appointment  Completed  Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Breastfeeding  Whole Milk Amount  Milk Intake/Weaning from bottleAdequate Weight Gain  Solids:  Soda  Juice  Supplements |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-1yr.html  First Steps  “Mama/Dada” Specific  Uses Single Words  Scribbles  Precise Pincer Grasp Follows Simple One Step Requests  Looks for Hidden Objects  Extends Arm/Leg for Dressing Points to ObjectsPlays: Hides Object/Pushes Ball Back and Forth  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention Car/Car Seat Safety (Rear-Facing)  Passive Smoke  Safety at Home/Child-Proofing  Sun Safety  Discipline/Praise Following Child’s Lead in Play  Ignore Tantrums/Give Attention to Positive Behaviors  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child Self-Calming  Prefers Primary Caregiver Over All Others  Shy/Anxious with Strangers  Tantrums  Other  |

U **COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

U **ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting Finger Stick  Venous (Result \_\_\_)  Hgb/Hct (Required, If not Done at 9 Months)  TB Skin Test (If at Risk)  Other  |
| **IMMUNIZATIONS ORDERED:** |  HepA  HepB MMR  Varicella  DTaP  Hib  IPV  PCV  Influenza  Had Chicken Pox  Other \_\_\_\_  Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: \_\_\_\_\_\_\_\_\_\_\_ Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |  ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other   |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**15 Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
|  **Yes** |  **No** |  **Yes** |  **No** |  |  |  |
|  **Allergies:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Vision Screening:** | **Corrected:**  **Yes**  **No** | **Automated Device**  | **Right:**  **Pass**  **Refer** | **Left:**  **Pass**  **Refer** | **Both:**  **Pass**  **Refer** |  **Unable to Perform** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about child? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child at Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice Daily by Parent)  Fluoride Supplement **Fluoride Varnish by PCP** (Every 3 Months) First Dental Appointment  Completed  Scheduled Dental Home Provider:  |
| **NUTRITIONAL SCREENING:**  Feeds Self  Breastfeeding  Whole Milk  Nutritionally Balanced Diet  Junk Food  Soda/Juice Solids  Activity  Supplements OverweightUnderweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:** <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-15mo.html> Says 3-6 words  Says No  Wide Range of Emotions  Repeats Words from Conversation Uses Utensils  Understands Simple Commands  Climbs Stairs  Walking  Puts Objects In/Out of Container  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency /911  Gun Safety  Drowning Prevention  Choking Prevention Car/Car Seat Safety (Rear-Facing)  Safety at Home/Child-Proofing  Sun Safety  Helmet Use  Growing Independence Defiant Behavior/Offer Child Choices  Gentle Limit Setting/Redirection/Safety  Reading/Parent Asks Child “What’s that? Follow Child’s Lead in Play  Offer Opportunity to Scribble/Explore  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child Appropriate Bonding/Responsive to Needs  Self-Calming  Frustration/Hitting/Biting/Impulse Control  Communication/Language Social Interaction/Eye Contact/Comforts Others  Begins to Have Definite Preferences  Other:  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting(Child At Risk/Not already Done at 12 Months)  Finger Stick (Result: )  Venous TB Skin Test (If at Risk)  Other  |
| **IMMUNIZATIONS ORDERED:** | HepA  HepB  MMR  Varicella DTaP  Hib  IPV  PCV  Influenza Had chicken pox  Other  Given at Today’s Visit  Parent Refused  Delayed Deferred Reason:  Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |  ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**18 Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
|  **Yes** |  **No** |  **Yes** |  **No** |  |  |  |
|  **Allergies:** | **Weight:** | **Length:** | **Head Circumference:** |
| **lb oz** | **%** | **cm** | **%** | **cm** | **%** |
| **Vision Screening:** | **Corrected:**  **Yes**  **No** | **Automated Device**  | **Right:**  **Pass**  **Refer** | **Left:**  **Pass**  **Refer** | **Both:**  **Pass**  **Refer** |  **Unable to Perform** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL /Health Care Decision Maker CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **DEVELOPMENTAL SCREENING TOOL COMPLETED:**  ASQMCHATPEDS |
| **VERBAL LEAD RISK ASSESSMENT:** Child at Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice Daily by Parent)  Fluoride Supplement FluorideVarnishbyPCP(Every 3 Months) First Dental Appointment  Completed  Scheduled Dental Home Provider:  |
| **NUTRITIONAL SCREENING:**  Feeds Self  Breastfeeding  Whole Milk  Nutritionally Balanced Diet  Junk Food Soda/Juice Solids  Activity  Supplements OverweightUnderweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-18mo.html  Uses a cup  Walks  Says 10-20 Words  Says “No”  Name One Picture/2 Colors Follows Simple Rules/Bring Me the Book  Knows Animal Sounds  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning prevention  Choking Prevention Car/Car Seat Safety (Rear-Facing)  Safety at Home/Child-Proofing  Sun Safety  Helmet Use  Never Leave Toddler Alone Sibling Interaction  Discipline/Limits  Growing Independence  Encourage Expression of Wide Range of Emotions  Read to Child  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to ChildAppropriate Bonding/Responsive to Needs  Self-Calming  Frustration/Hitting/Biting/Impulse Control  Communication/LanguageDemonstrates Increasing Independence Defiant Behavior/Offer Child Choices  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting(Child at Risk/Not already Done at 12 Months)  Finger Stick (Result: \_\_\_\_)  Venous  TB Skin Test (If at Risk)  Other |
| **IMMUNIZATIONS ORDERED:** |   HepA  HepB  MMR  Varicella  DTaP  Hib  IPV  PCV  Influenza Had chicken pox  Other  Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason:   Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |   ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:   Developmental  Behavioral  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**24 Months Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admitted to NICU:** (Birth) | **Current Medications/Vitamins/Herbal Supplements:** | **Risk Indicators of Hearing Loss:** | **Temp:** | **Pulse:** | **Resp:** |
| **Yes** | **No** | **Yes** | **No** |  |  |  |
|  **Allergies:** | **Weight:** | **Length:** | **Head Circumference:** | **BMI:** |
| **lb oz** | **%** | **cm** | **%** | **cm** | **%** | **kg/m2** | **%** |
|  **Vision Screening:** | **Corrected:**  **Yes**  **No** | **Automated Device**  | **Right:**  **Pass**  **Refer** | **Left:**  **Pass**  **Refer** | **Both:** **Pass**  **Refer** | **Unable to Perform** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about baby? Do you feel safe in your home?

|  |
| --- |
| **DEVELOPMENTAL SCREENING TOOL COMPLETED:** ASQMCHATPEDS |
| **BLOOD LEAD LEVEL REQUIRED**  (see below) |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice Daily by Parent)  Fluoride Supplement FluorideVarnishbyPCP (Every 3 months)2First Dental Appointment  Completed Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Feeds Self  Nutritionally Balanced Diet  Junk Food  Soda/JuiceActivity Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Overweight  Underweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html  Kicks a Ball  Stacks 5-6 Blocks  50 Word Vocabulary  Walks Upstairs/Runs WellPut Two Words Together  Jumps Up  Follows Two Step Commands https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html Ohttps://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yhttps://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.htmlhttps://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking PreventionCar /Car Seat Safety (Forward Facing)  Safety at Home/Child-Proofing  Sun Safety  Trike/Bike Safety (Helmet Use)Establish Daily Routine  Discipline/Redirection/Praise  Provide Opportunities for Success/Choice  Praise for Effort/SuccessEncourage/Support Wide Range of Emotions  Read to Child  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child  Self-Calming Appropriate Bonding/Responsive to Needs  Frustration/Hitting/Biting/Impulse Control  Communication/LanguageSense of Humor  Demonstrates Increasing Independence  Plays Alongside Peers Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision/Red Reflex |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW-UP:**

|  |  |
| --- | --- |
| **LABS ORDERED:** | BloodLeadTesting Finger Stick (Result)  Venous  TB Skin Test (If at Risk) Other \_\_\_\_\_\_\_ |
| **IMMUNIZATIONS ORDERED:** | HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza Had Chicken Pox  Other Given at Today’s Visit  Parent Refused Delayed Deferred Reason: Shot Record Updated  Entered in ASIIS Importance of Immunizations Discussed  Parent Refusal Form Completed |  |
| **REFERRALS:** | ALTCS  Audiology  AzEIP  CRS  DDD  Dental  Early Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**30 Months Old - AHCCCS EPSDT Clinical Sample Template**

 **Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
|  **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Screening:** | **Corrected:** **Yes** **No** | **Device** **Chart** | **Right:** **Pass** **Refer** | **Left:** **Pass** **Refer** | **Both:** **Pass** **Refer** |
| **Hearing Screening:** |  **Right** **Pass** **Refer** |  **Left** **Pass** **Refer** |  **Unable to Perform** |  **Age-Appropriate Speech:** |  |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about your child? Do you feel safe in your home?

 **DEVELOPMENTAL SCREENING TOOL COMPLETED:** ASQMCHATPEDS

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No Daily Brushing with help (Twice Daily by Parent) Fluoride Supplement FluorideVarnishbyPCP (Every 3 months)Last Dental Appointment: Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:** Nutritionally Balanced Diet Junk Food Soda/Juice  Supplements  Activity/Family Exercise Overweight UnderweightObservation Referral |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-30mo.htmlUses Imaginary Characters/Plays Pretend Puts 3-5 Words Together Points to 6 body parts Other people can understand what your child is saying half the time Names Self & Others Begins to Play Interactive Games Jumps Up and Down in Place Puts on clothes with help Knows correct animal sound (i.e. cat meows) Washes and dries hands without help Other https://www.cdc.gov/ncbddd/actearly/milestones/milestones-30mo.html |
| **ANTICIPATORY GUIDANCE PROVIDED:** Emergency/911 Gun Safety  Drowning Prevention Choking PreventionCar /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Sports/Helmet Use TV Screen TimeSupervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting PreschoolProvide Opportunities for Fantasy Play/Problem Solving Allow Child to Play Independently/Be Available if Child Seeks You OutEncourage Literacy/Daily Reading Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):** Family Adjustment/Parent Responds Positively to Child Manage Anger “Monster” Fear Frustration/Hitting/Biting/Impulse Control Separates Easily from Parent Shows Interest in Other ChildrenObjects to Major Change in Routine Kind to Animals Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** | BloodLeadTesting(Child At Risk/Not Already Done at 12/24 Months) TB Skin Test (If at Risk) Hgb/Hct Other \_\_\_ |
| **IMMUNIZATIONS ORDERED:** | HepA HepB  MMR Varicella DTaP Hib IPV PCV  Influenza Had Chicken Pox Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shot Record Updated  Entered in ASIIS Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS** | ALTCS Audiology ACC DDD Dental  Head Start OT PT Speech WIC Specialist Developmental Behavioral Other   |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Three Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
|  **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
|  **Vision Screening:** |  **Corrected:**  **Yes**  **No** | **Device**  **Chart** | **Right:**  **Pass**  **Refer** | **Left:**  **Pass**  **Refer** | **Both:**  **Pass**  **Refer** |
|  **Hearing Screening:** | **Right  Pass  Refer** | **Left  Pass  Refer** | **Unable to Perform** | **Age-Appropriate Speech:** |  |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about your child? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice Daily by Parent) Fluoride Supplement FluorideVarnishbyPCP (Every 3 months)Last Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet  Junk Food  Soda/Juice  Supplements  Activity/Family Exercise  Overweight  Underweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-3yr.html  Uses Imaginary Characters  Matches Colors and Shapes  Counts to 5  Knows Gender Names Self & Others  Begins to Play Interactive Games  Stand on One Foot  Communication/Language  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention  Sun Safety Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing  Sports/Helmet Use  TV Screen Time  Preschool Supervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting Encourage Literacy Provide Opportunities for Fantasy Play/Problem Solving  Allow Child to Play Independently/Be Available if Child Seeks You Out Other |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child Manage Anger  “Monster” Fear  Frustration/Hitting/Biting/Impulse Control  Separates Easily from Parent Objects to Major Change in Routine  Shows Interest in Other Children  Kind to Animals  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** | BloodLeadTesting(Child at Risk/Not Already Done at 12/24 Months)  TB Skin Test (If at Risk)  Hgb/Hct  Other  |
| **IMMUNIZATIONS ORDERED:** | HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza Had Chicken PoxGiven at Today’s Visit Parent Refused Delayed Deferred Reason: Shot Record Updated  Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed |
| **REFERRALS** | ALTCS Audiology ACC DDD Dental Head Start OT PT Speech  WIC Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Four Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
|  **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Screening:** |  **Corrected: Yes No** |  **Device  Chart ** |  **Right:  Pass  Refer** |  **Left:  Pass  Refer** |  **Both:  Pass  Refer** |
| **Hearing Screening:** | **Right:  Pass  Refer** | **Left:  Pass  Refer** | ** Unable to Perform** | **Age-Appropriate Speech:** | ** Yes  No** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about child? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing (Twice Daily by Parent) FluorideSupplementFluorideVarnishbyPCP (Every 3 months)Last Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:** Nutritionally Balanced Diet  Junk Food Soda/Juice Supplements Activity/Family Exercise Overweight UnderweightObservation  Referral |
| **DEVELOPMENTAL SURVEILLANCE**: https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4yr.html Sings a Song Draws a Person with 3 Parts Names Self & Others Names 4 Colors/3 Shapes Counts 1-7 Objects Out Loud (Not Always in Order) Shows Interest in Other Children Dresses Self Brushes Own TeethAsks/Answers - Who, What, Where, Why  Follows 2 Unrelated Directions Balances/Hops on One Foot Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911 Gun Safety Drowning Prevention Choking Prevention Sun SafetyCar /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sports/Helmet Use Good and Bad Touches Positive Discipline / Redirect  Reading/Preschool School Readiness Allow Child to Play Independently/be Available if Child Seeks You Out Other |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):** Family Adjustment/Parent Responds Positively to Child Self-Calming Separates Easily from Parent Kind to Animals Objects to Major Change in Routine  Has Words for FeelingsOther |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting(Child at Risk/Not Already Done at 12/24 Months)  TB Skin Test (If at Risk)  Hgb/Hct  Other  |
| **IMMUNIZATIONS ORDERED:** |  HepA  HepB  MMR  Varicella  DTaP  Hib  IPV  PCV  Influenza  Had Chicken Pox Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |  ALTCS  Audiology  CRS  DDD  Dental  Head Start  OT  PT  Speech  WIC Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Five Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
|  **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Screening:** | **Corrected:**  **Yes**  **No** | **Device**  **Chart**  | **Right:**  **Pass**  **Refer** | **Left:**  **Pass** **Refer** |  **Both:**  **Pass**  **Refer** |
|  **Hearing Screening:** | **Right**  **Pass**  **Refer** | **Left**  **Pass**  **Refer** |  **Unable to Perform** | **Age-Appropriate Speech:** |  Yes  No |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How do you feel about your child? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Twice Daily Brushing/Flossing (With Parent Assistance) FluorideSupplementLast Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet/5 Servings Fruits & Veggies  Junk Food  Soda/Juice  Supplements Activity/Family Exercise (1hr/day) OverweightUnderweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:** https://www.cdc.gov/ncbddd/actearly/milestones/milestones-5yr.html  Uses Imaginary Characters  Matches Colors & Shapes/Prints Some Numbers and Letters Counts to 10 Follows Simple Directions Listens and Attends Can Button & Zip Clothing Independently Goes to Bathroom Independently  Holds Pencil/Cuts with Scissors  Cooperates More in Group Setting  Good Articulation/Language Skills  Hops/Skips https://www.cdc.gov/ncbddd/actearly/milestones/milestones-5yr.html Other \_\_\_\_\_\_\_\_\_ |
| **ANTICIPATORY GUIDANCE PROVIDED**:  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention Car /Car Seat Safety (Booster Seat for under 4’9” height)  Safety at Home  Sun Safety  Sports/Helmet Use  Bullying Good and Bad Touches TV Screen Time  Begins to Agree with Rules  Dictates Story to Adults  Listens to Authority Figure & Follows Instructions School Readiness  Communication with Teachers  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child  Self-Calming  Wants to Please & Be with Friends  Shows Empathy for Others  Positive about Self & Abilities  Tells Stories of Convenience (Lying)  Other \_\_\_\_\_\_\_\_\_ |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
|  **LABS ORDERED:** |  BloodLeadTesting(Child at Risk/Not Already Done at 12/24 Months)  TB Skin Test (If at Risk)  Hgb/Hct  Other  |
|  **IMMUNIZATIONS ORDERED:** |  HepA  HepB  MMR  Varicella  DTaP  Hib  IPV  Influenza Had Chicken Pox Given at Today’s Visit  Parent Refused  Delayed Deferred Reason:  Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |   ALTCS  Audiology  CRS  DDD  Dental  Head Start  OT  PT  Speech   WIC Specialist:  Developmental  Behavioral  Other   |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Six Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
| **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Screening: Record Abnormal Results Below** | **Corrected:** **Yes**  **No** | **Right:** **Pass**  **Refer** | **Left:** **Pass**  **Refer** | **Both:**  **Pass**  **Refer** |   **Unable to Perform** |
| **Audiometry:** | **Within Normal Limits** | **Abnormal** |  | **Age-Appropriate Speech:** |  **Yes** |  **No** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/Health Care Decision Maker CONCERNS:** How do you feel about your child? Do you feel safe in your home?

|  |
| --- |
| **VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (If Yes, Appropriate Action to Follow)  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Twice Daily Brushing/Flossing (with Parent Assistance)  Sealants **** Fluoride SupplementLast Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet/5 Servings Fruits & Veggies  Junk Food  Soda/Juice  Supplements  Activity/Family Exercise (1 hr/day) **** Overweight **** Underweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:**  Expressive & Understandable Language  School Attendance  Reading at Grade LevelFollows Simple Directions  Prints Some Letters & Numbers  Balances on One Foot  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention Car /Car Seat Safety (Booster Seat for under 4’9” height)  Safety at Home  Sun Safety  Sport/Helmet Use  Bullying  Street safety TV Screen Time  Positive Discipline/Redirect  Provide Opportunities for Social Interaction  Age Appropriate Chores Daily Reading Other  |
| **SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT)**:  Family Adjustment/Parent Responds Positively to ChildFrustration/Impulse Control Communication/Language  Has Friends  Plays Well with Others/By Self  Feels Capable Is Liked by Other Children  Expresses Full Range of Emotions  Anger Control  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  BloodLeadTesting(Child at Risk/Not Already Done at 12/24 Months)  TB Skin Test (If at Risk) Hgb/Hct  Other |
| **IMMUNIZATIONS ORDERED:** |  HepA  HepB  MMR  Varicella  DTaP  Hib  IPV  Influenza  Had Chicken Pox Given at Today’s Visit Parent Refused Delayed  Deferred Reason:  Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** |  ALTCS  Audiology  CRS  DDD  Dental  OT  PT  Speech Specialist  Developmental  Behavioral  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Provider’s** **Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Seven to Eight Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
|  **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Chart Exam:** | **Right** | **Left** | **Both** | **Corrected**  **Yes**  **No** |  **Unable to Perform** |
| **Audiometry:** |  **Within Normal Limits** |  **Abnormal** |  | **Age Appropriate Speech:** |  **Yes** |  |  **No** |

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL/HEALTH CARE DECISION MAKER CONCERNS:** How do you feel about your child? Do you feel safe in your home?

|  |
| --- |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing 2x Daily/Flossing  Dental Sealants **** FluorideSupplementLast Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet/5 Servings Fruits & Veggies  Low-Fat Milk  Junk Food  Soda/JuiceSupplements  Activity/Family Exercise (1 hr/day) OverweightUnderweight Observation Referral |
| **DEVELOPMENTAL SURVEILLANCE:**  School Attendance Reading at Grade Level  School Performance  IEP/504 PlanDiscuss Body Changes Has Friends  Does Chores When Asked Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:** Emergency/911 Gun Safety Drowning Prevention Choking Prevention Car /Car Seat Safety (Booster Seat for under 4’9” height) Safety at Home Sun Safety  Sport/Bike Helmet Use Bullying/FightingStreet Safety  Smoke-Free Environment Positive Discipline  Reading  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT)**:  Family Adjustment/Parent Responds Positively to ChildFrustration /Impulse Control  Communication/Language  Comfortable Body Image  Encourage IndependencePraise Strengths  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** | TB Skin Test (If at Risk)  Hgb/Hct Other  |
| **IMMUNIZATIONS ORDERED:** | HepA  HepB  MMR  Varicella  Td  IPV  Influenza  Had Chicken Pox  Other Given at Today’s Visit  Parent Refused Delayed Deferred Reason: Shot Record Updated  Entered in ASIIS Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  CRS DDD Dental  OT  PT Speech Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**Nine to Twelve Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
| **Allergies:** | **Weight:** | **Height:** | **BMI:** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Chart Exam:** | **Right** | **Left** | **Both** | **Corrected  Yes  No** | **Unable to Perform** |
| **Audiometry:** | **Within Normal Limits** | **Abnormal** |  **Unable to perform** | **Menses:** | **Menarche:** | **LMP:** |
| **FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns) |  **Yes**  **No** |  |  |

**PARENTAL/Health Care Decision Maker CONCERNS:** How do you feel about your child? Do you feel safe in your home?

|  |
| --- |
| **HEALTH RISK ASSESSMENT:**  Early Adolescent GAPS (Beginning at 10 Years)  Other  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing 2x Daily/Flossing  Dental Sealants  Fluoride SupplementLast Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**   Nutritionally Balanced Diet  5 Servings of Fruits & Veggies  Junk Food  Soda/ Energy Drinks Supplements  Activity/Family Exercise (1 hr/day)  Overweight  Underweight Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:**  School Attendance  Reading at Grade Level  Discuss Body Changes  Dating Sexuality/Orientation  Performing Well in School  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention Car/Seat Belt Safety  Safety at Home  Sports/Injury Prevention  Bullying /Violence Prevention  Sun Safety Safety Rules with Adults  Sex Education/STI  Monitor TV/Computer Time  Peer Refusal Skills  Self-Control Depression/Anxiety  Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants  Risks of Tattoos/ Piercing After-School Activities/Supervision  Educational Goals/Activities  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT)**:  Comfortable Body Image  Feels Good About Self Is Child Happy?  Social Interaction  Suicide Screen (10 years of age or greater)  SUD Screen (12 years of age)  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | Genitourinary**Tanner Stage** |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** |  TB Skin Test (If at Risk)  Hgb/Hct  Other |
| **IMMUNIZATIONS ORDERED:** | Tdap **(**11 – 12 Years) Meningococcal (11 – 12 Years)  HPV (11 – 12 Years) HepA  HepB MMR Varicella  Td  IPV  Influenza  Had Chicken Pox  Other Given at Today’s Visit Parent Refused  Delayed  Deferred Reason: Shot Record Updated Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  CRS  DDD  Dental  OB/GYN  OT  PT  Speech Specialist:  Developmental  Behavioral  Other   |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**13 TO 17 YEARS OLD - AHCCCS EPSDT CLINICAL SAMPLE TEMPLATE**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
| **Allergies:** | **Weight:** | **Height:** | **BMI** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Chart Exam:** | **Right** | **Left** | **Both** | **Corrected**  **Yes**  **No** |  **Unable to Perform** |
| **Audiometry:** | **Within Normal Limits** | **Abnormal** |  | **Unable to perform** | **Menses:** | **Menarche:** | **LMP:** |
| **FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns) | **Yes** **No** |  |  |

 **PARENTAL/Health Care Decision Maker CONCERNS:** How are you feeling about your teenager? Do you feel safe in your home?

|  |
| --- |
| **HEALTH RISK ASSESSMENT:**  HEADSS  GAPS  Other  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing 2x Daily/Flossing  Fluoride SupplementLast Dental Appointment: Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet 5 Servings of Fruits & Veggies Junk Food Soda/ Energy DrinksSupplements  Activity/Exercise (1 hr/day)  Overweight  Underweight  Observation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:**  School Attendance Reading at Grade Level  Dating  Sexuality/OrientationRisk-Taking  Other  |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Violence Prevention/Gun Safety/Bullying  Drowning/Sun SafetyCar/Seat Beat/Driving Safety  Safety at Home  Sports/Injury prevention  Peer Refusal Skills  Age-Appropriate LimitsSexual Orientation/Dating  Sex Education/STI/Resources  Availability of Family Planning Services  Social InteractionTobacco/Alcohol/Drugs/Rx Drugs/Inhalants  Risks of Tattoos/ Piercing  Educational Goals/Activities  Job/Career PlanningCommunity Involvement  After-School Activities/Supervision  Other  |

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | GenitourinaryTanner Stage |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** | TB Skin Test (If at Risk)  Hgb/Hct  Lipid Profile [ ]  Syphilis Test (15 years +)  Other |
| **IMMUNIZATIONS ORDERED:** | HepA  MMR  Varicella  Hep B  Tdap  Influenza  Meningococcal  HPV  IPV  Td  Had Chicken Pox Other Given at Today’s Visit  Parent Refused  Delayed  Deferred Reason: Shot Record Updated  Entered in ASIIS  Importance of Immunizations Discussed  Parent Refusal Form Completed |
| **REFERRALS:** | ALTCS  Audiology  CRS  DDD  Dental  PT  OT  OB/GYN  Speech Specialist:  Developmental  Behavioral  Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**18 to 21 Years Old - AHCCCS EPSDT Clinical Sample Template**

**Date Last Name First Name AHCCCS ID # DOB Age**

**Primary Care Provider PCP ph. # Health Plan Accompanied By (Name) Relationship**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications/Vitamins/Herbal Supplements:** | **Blood Pressure:** | **Temp:** | **Pulse:** | **Resp:** |
|  |  |  |  |
| **Allergies:** | **Weight:** | **Height:** | **BMI** |
| **lb / kg** | **%** | **cm** | **%** | **kg/m2** | **%** |
| **Vision Chart Exam:** | **Right** | **Left** | **Both** | **Corrected  Yes  No** | **Unable to Perform** |
| **Audiometry:** | **Within Normal Limits** | **Abnormal** |  | **Unable to perform** | **Menses:** | **Menarche:** | **LMP:** |
| **FAMILY/SOCIAL HISTORY/CONCERNS:** (Current Concerns/ Follow-Up on Previously | **Yes  No** |  |  |

Identified Concerns)

|  |
| --- |
| **HEALTH RISK ASSESSMENT:**  HEADSS  GAPS  Other  |
| **ORAL HEALTH:** White Spots on Teeth:  Yes  No  Daily Brushing 2x Daily/Flossing **** Fluoride SupplementLast Dental Appointment:  Future Dental Appointment Scheduled Dental Home: Provider Name  |
| **NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet  5 Servings of Fruits & Veggies  Junk Food  Soda/ Energy DrinksSupplements  Activity/Exercise (1 hr/day) **** Overweight UnderweightObservation  Referral |
| **DEVELOPMENTAL SURVEILLANCE:**  Abstract Thinking  School Attendance  Sexuality/OrientationPhysical Growth and Development  Other ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Violence Prevention/Gun Safety/Bullying  Drowning/Sun SafetyCar/Seat Beat/Driving Safety  Safety at Home  Sports/Injury prevention  Peer Refusal Skills  Age-Appropriate LimitsSexual Orientation/Dating  Sex Education/STI/Resources  Availability of Family Planning Services  Social InteractionTobacco/Alcohol/Drugs/Rx Drugs/Inhalants  Risks of Tattoos/ Piercing  Educational Goals/Activities  Job/Career PlanningCommunity Involvement  After-School Activities/Supervision  Other  |
| **SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT)**:  Philosophical/Idealistic  Comfortable Body ImageSelf-Confident  Building Intimate/ Complex Relationships  Depression/Anxiety/Sleep Issues  Mood Changes  Suicide Screen   |

 SUD Screen

**COMPREHENSIVE PHYSICAL EXAM:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **WNL** | **Abnormal (see notes below)** |  | **WNL** | **Abnormal (see notes below)** |
| Skin/Hair/Nails |  |  | Lungs |  |  |
| Eyes/Vision |  |  | Abdomen |  |  |
| Ear |  |  | GenitourinaryTanner Stage |  |  |
| Mouth/Throat/Teeth |  |  | Extremities |  |  |
| Nose/Head/Neck |  |  | Spine |  |  |
| Heart |  |  | Neurological |  |  |

**ASSESSMENT/PLAN/FOLLOW UP**

|  |  |
| --- | --- |
| **LABS ORDERED:** | TB Skin Test (If at Risk)  Hgb/Hct  Lipid Profile [ ]  Syphilis Test (15 years +)  Other  |
| **IMMUNIZATIONS ORDERED:** | HepA  MMR  Varicella  Hep B Tdap  Influenza Meningococcal  HPV  IPV  Td Had Chicken Pox Other  Given at Today’s Visit Refused Delayed  Deferred Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Shot Record Updated/Entered in ASIIS  Importance of Immunizations Discussed  Refusal Form Completed |
| **REFERRALS:** | ALTCS Audiology  CRS  DDD  Dental  OB/GYN PT  OT  Speech Specialist: Developmental Behavioral Other  |
| **Provider’s Signature:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |