APPENDIX B

EPSDT STANDARDS AND TRACKING FORMS

AHCCCS EPSDT TRACKING FORMS

The Arizona Health Care Cost Containment System (AHCCCS) EPSDT Tracking Forms must be used by all providers offering care to AHCCCS members less than 21 years of age to document age-specific, required information related to EPSDT screenings and visits. Only AHCCCS EPSDT Tracking Forms may be used; paper form substitutes are not acceptable. However, the provider may choose to utilize an electronic EPSDT Tracking Form generated through AHCCCS (once available) or the provider's electronic health record system, so long as the electronic form includes all components present on the AHCCCS EPSDT Tracking Form. These components include, but are not limited to:

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

Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

AHCCCS Contractors are required to print two-part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor's EPSDT Coordinator) and distribute these forms to their contracted providers. Providers may also choose to print the EPSDT Tracking Form from the AHCCCS website.

A copy of the completed EPSDT Tracking Form, signed by the clinician, should be placed in the member's medical record. Depending on the member's enrollment status, an additional distributed copy of the EPSDT Tracking Form may be required, as detailed below.

- For members enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.
- For AHCCCS Fee-For-Service members [e.g., enrolled in the American Indian Health Program (AIHP)], the provider should maintain a copy of the EPSDT Tracking Form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce EPSDT Tracking Forms as needed. All others may reproduce the forms with permission of AHCCCS via an approved written request directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6700
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. *Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.*

Contact information for AHCCCS Contracted health care plans may be found at www.ahcccs.state.az.us.

Revised: 04/01/2014, 10/01/2009, 07/01/2001, 11/01/2007, 01/01/2004, 11/01/2003, 06/01/2003

3-5 Days Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: 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 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
☐ **Formula** *Type:* _____ *Amount/Duration*: _____ **Adequate Weight Gain** ☐ Yes ☐ No ☐ **Receiving WIC Services**

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 ☐ Baby Blues/Postpartum Depression ☐ 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 HEPB ADMINISTERED:** _____ ☐ HepB *(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)*

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

1 Month Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: 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 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
☐ **Formula** *Type:* _____ *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 ☐ 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 ☐ 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 ☐ 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: **DATE 1ST HEPB/2ND HEPB ADMINISTERED:** _____/_____ ☐ HepB *(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)*

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

2 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: 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 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
☐ **Formula** *Type:* _____ *Amount/Duration*: _____ **Adequate Weight Gain** ☐ Yes ☐ No ☐ **Receiving WIC Services**

DEVELOPMENTAL SURVEILLANCE: ☐ 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
☐ Postpartum Depression ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

4 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

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

PARENTAL 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
☐ **Formula** *Type:* _____ *Amount/Duration*: _____ **Adequate Weight Gain** ☐ Yes ☐ No ☐ **Receiving WIC Services**
☐ Cereal *Type:* _____ ☐ Plan to Introduce Solids_____ ☐ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: ☐ 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 (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 ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

6 Months Old — AHCCCS EPSDT Tracking Form

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 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 ☐ **Fluoride Varnish by PCP**

NUTRITIONAL SCREENING: ☐ **Breastfeeding** *Frequency/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: ☐ 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/Child-Proofing ☐ Sun Safety ☐ Refrain From Jump Seat/Walker ☐ Sleep/Wake Cycle ☐ Introduce Cup ☐ Begin Using High Chair ☐ 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 ☐ 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: ☐ **Blood Lead Testing** *(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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

9 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

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

PARENTAL 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 ☐ **Fluoride Varnish by PCP** *(Once Every 6mo)*

NUTRITIONAL SCREENING: ☐ **Breastfeeding** ☐ **Formula** *Amount*: _____ ☐ **Supplements**: _____ ☐ Vit D ☐ **Receiving WIC Services**
Adequate Weight Gain ☐ Yes ☐ No Plan to Introduce Table Foods _____ ☐ Drinks From Cup ☐ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: ☐ 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 ____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention
☐ Choking Prevention/Soft Texture Finger Foods ☐ Car/Car Seat Safety *(Rear-Facing)* ☐ Safe Sleep ☐ Shaken Baby Prevention
☐ Passive Smoke ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Sleep/Wake Cycle ☐ TV Screen Time ☐ Exploration/Learning
☐ Redirection/Positive Parenting ☐ 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: ☐ **Blood Lead Testing** *(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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

12 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

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

PARENTAL CONCERNS: *How are you feeling about baby? Do you feel safe in your home?*

VERBAL LEAD RISK ASSESSMENT: ***(Blood Lead Test Required)*** Child At Risk ☐ *Yes* ☐ *No* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: White Spots on Teeth: ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice by Parent)* ☐ Fluoride Supplement ☐ **Fluoride Varnish by PCP**
First Dental Appointment ☐ *Completed* ☐ *Scheduled* Dental Home: Provider Name_____ *(Once Every 6mo)*

NUTRITIONAL SCREENING: ☐ Breastfeeding ☐ Whole Milk *Amount* _____ ☐ Milk Intake/Weaning
☐ Adequate Weight Gain ☐ Solids: _____ ☐ Soda ☐ Juice ☐ Supplements

DEVELOPMENTAL SURVEILLANCE: ☐ 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 _____

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: ☐ **Blood Lead Testing** *(Required)* ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

15 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Weight: lb oz %	Length: cm %	Head Circumference: cm %

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

PARENTAL 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice Daily by Parent)* ☐ Fluoride Supplement
☐ **Fluoride Varnish by PCP** *(Once Every 6 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: ☐ 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: ☐ **Blood Lead Testing** *(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* _____

Date/Time _____ Clinician Name (Print) _____ Clinician Signature _____ NPI # _____ See Additional Supervisory Note ☐ **Yes** ☐ **No**

18 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Weight: lb oz %	Length: cm %	Head Circumference: cm %

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

PARENTAL 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice Daily by Parent)* ☐ Fluoride Supplement
☐ **Fluoride Varnish by PCP** *(Once Every 6 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: ☐ 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: ☐ **Blood Lead Testing** *(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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

24 Months Old — AHCCCS EPSDT Tracking Form

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/m^2	%

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

PARENTAL 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: ***(Blood Lead Test Required)*** Child At Risk ☐ *Yes* ☐ *No* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice Daily by Parent)* ☐ **Fluoride Supplement**
First 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: ☐ Kicks a Ball ☐ Stacks 5-6 Blocks ☐ 50 Word Vocabulary ☐ Walks Upstairs/Runs Well
☐ Put Two Words Together ☐ Jumps Up ☐ Follows Two Step Commands ☐ Other _____

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
☐ Appropriate Bonding/Responsive to Needs ☐ Self-Calming ☐ 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: ☐ **Blood Lead Testing** (*Required*) ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

3 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform

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 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing (Twice Daily by Parent) ☐ **Fluoride Supplement**
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: ☐ 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
☐ 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 ☐ 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: ☐ **Blood Lead Testing** *(Child at Risk/Not Already Done at 12/24Months)* ☐ 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* _____

Date/Time _____ Clinician Name (Print) _____ Clinician Signature _____ NPI # _____ See Additional Supervisory Note ☐ **Yes** ☐ **No**

4 Years Old — AHCCCS EPSDT Tracking Form

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: lb / kg	Weight: %	Height: cm	Height: %	BMI: kg/m²	BMI: %

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform
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 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice Daily by Parent)* ☐ **Fluoride Supplement**
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: ☐ 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
☐ Car /Car Seat Safety *(Forward Facing)* ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ 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: ☐ **Blood Lead Testing** *(Child at Risk/Not Already Done at 12/24Months)* ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

5 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform
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 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Twice Daily Brushing/Flossing *(With Parent Assistance)* ☐ **Fluoride Supplement**
Last 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: ☐ Uses Imaginary Characters ☐ Matches Colors and 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 ☐ Other_____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car /Car Seat Safety *(Booster Seat)* ☐ 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: ☐ **Blood Lead Testing** *(Child at Risk/Not Already Done at 12/24Months)* ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

Revised 04/01/2014

6 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

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 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Twice Daily Brushing/Flossing *(with Parent Assistance)* ☐ Sealants ☐ **Fluoride Supplement**
Last 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: ☐ 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)* ☐ 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: ☐ **Blood Lead Testing** *(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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

7-8 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

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 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 ☐ **Fluoride Supplement**
Last 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 (1hr/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)* ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

9-12 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform

Audiometry:	☐ Within Normal Limits	☐ Abnormal	☐ Unable to perform

Menses:	Menarche:	LMP:
☐ Yes ☐ No		

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

PARENTAL 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 Supplement**
Last 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 (1hr/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 ☐ 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 Only)** ☐ Meningococcal **(11 – 12 Years Only)** ☐ 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* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

13-17 Years Old — AHCCCS EPSDT Tracking Form

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: lb / kg	Weight: %	Height: cm	Height: %	BMI: kg/m^2	BMI: %

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform

Audiometry: ☐ Within Normal Limits ☐ Abnormal ☐ Unable to perform	Menses:	Menarche:	LMP:
	☐ Yes ☐ No		

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

PARENTAL CONCERNS: *How are you feeling about your teenager? Do you feel safe in your home?*

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other _____

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing 2x Daily/Flossing ☐ **Fluoride Supplement**
Last 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 (1hr/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 _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Comfortable Body Image ☐ Mental Health Concerns
☐ Dealing with Stress ☐ Depression/Anxiety ☐ Decision-Making ☐ 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 ☐ Lipid Profile ☐ Other _____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ MMR ☐ Varicella ☐ HepB ☐ 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 ☐ OB/GYN ☐ OT ☐ Speech
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**

18-21 Years Old — AHCCCS EPSDT Tracking Form

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/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform

Audiometry:	☐ Within Normal Limits	☐ Abnormal	☐ Unable to perform

Menses:	Menarche:	LMP:
☐ Yes ☐ No		

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

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other _____

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing 2x Daily/Flossing ☐ **Fluoride Supplement**
Last 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 (1hr/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 ☐ Drowning/Sun Safety
☐ Car/Seat Belt/Driving Safety ☐ Safety at Home ☐ Sports/Injury Prevention ☐ Peer Refusal Skills ☐ Age Appropriate Limits
☐ Self-Control ☐ Sex Education/STI/Resources ☐ Availability of Family Planning Services ☐ Social Interaction/Dating
☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐ Risks of Tattoos/ Piercing ☐ Education Goals/Activities ☐ Job/Career Planning
☐ Parenting Advice *(As Appropriate)* ☐ 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 ☐ 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 ☐ Lipid Profile ☐ Other _____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ MMR ☐ Varicella ☐ HepB ☐ 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 ☐ PT ☐ OB/GYN ☐ OT ☐ Speech
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note ☐ **Yes** ☐ **No**