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 p~~P~~roviders 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.
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)* ☐ 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/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

☐ **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 Adjust-

ment/Parent Responds Positively to Child ☐ Appropriate Bonding/Responsive to Needs ☐ Infant Hands to Mouth/Self-Calming ☐ Postpartum Depression Screen

☐ Other _____

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24, 10/01/25, 10/01/26

Approval Dates: 07/01/01, 06/01/03, 11/01/03, 01/01/04, 11/01/07, 10/01/09, 04/01/14, 10/18/18, 02/21/19, 04/16/20, 10/07/21, 7/14/22,08/17/23, 08/26/24, 09/17/25, 05/15/26

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)* ☐ 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/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

☐ **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 ☐ 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: **DATE 1st HEP B/2nd 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:** _____

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)* ☐ 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/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

☐ **Formula** *Type*:_____ *Amount/Duration*: _____ **Adequate Weight Gain** ☐ Yes ☐ No ☐ **Receiving WIC Services**

DEVELOPMENTAL SURVEILLANCE: ~~https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2mo.html~~[1]

☐ 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 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		

[1] Removed milestone links thoughout.

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		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: ☐ **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: ~~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

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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ 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/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

ORAL HEALTH: ☐ Parent Cleaning Baby's Gums with Washcloth/Infant Toothbrush ☐ Fluoride Supplement

☐ **Fluoride Varnish by PCP** *(Every 3 months)*

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: ~~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 ☐ Postpartum Depression Screen ☐ 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 ~~Led~~ Lead[2] Testing** *(Child at Risk)* ☐ Finger Stick (*Result*:) ☐ Venous ☐ Other

IMMUNIZATIONS ORDERED: ☐ Hep B ☐ 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:** _____

[2] Typo revised throughout attachment.

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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ 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/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 ☐ **Fluoride Varnish by PCP** *(every 3 months)*

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: ~~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_____

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/Childproofing ☐ 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: ☐ Blood ~~Led~~ 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

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: ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ Yes ☐ No	Temp:	Pulse:	Resp:

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

☐ **Fluoride Varnish by PCP** *(Every 3 months)* First Dental Appointment ☐ *Completed* ☐ *Scheduled* ☐ Dental Home: Provider Name_____

_____

NUTRITIONAL SCREENING: ☐ Breastfeeding ☐ Whole Milk *Amount*____ ☐ Milk Intake/Weaning from bottle

Adequate Weight Gain ☐ Yes ☐ No ☐ 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_____

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 ~~Led~~ Lead Testing** ☐ 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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ Yes ☐ No	Temp:	Pulse:	Resp:

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

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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ Yes ☐ No	Temp:	Pulse:	Resp:

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

☐ **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-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: ☐ 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 _____

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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Weight: lb oz	%	Length: cm	%	Head Circumference: cm	%	BMI kg/m^2	%

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

☐ **Fluoride Varnish by PCP** *(Every 3 months)* 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: 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 ☐ 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 ☐ 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: ☐ **Blood Lead Testing** ☐ 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 Pres-	Temp:	Pulse:	Resp:

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

Vision Screening:	Corrected: ☐ Yes ☐ No	Automated Device ☐	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 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 *(Twice Daily by Parent)* ☐ Fluoride Supplement

☐ **Fluoride Varnish by PCP** *(Every 3 months)* Dental Appointment ☐ *Completed* ☐ *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 _____

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 _____

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24, 10/01/25, 10/01/26

Approval Dates: 07/01/01, 06/01/03, 11/01/03, 01/01/04, 11/01/07, 10/01/09, 04/01/14, 10/18/18, 02/21/19, 04/16/20, 10/07/21, 7/14/22,08/17/23, 08/26/24, 09/17/25, 05/15/26

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: ☐ 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 ☐ 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 Pres-	Temp:	Pulse:	Resp:

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

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 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 ☐ **Fluoride Varnish by PCP** *(Every 3 months)* Last Dental Appointment:_____ ☐ Future Dental Appointment

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 ☐ Pre-school
☐ 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: ☐ 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 ☐ 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 Pres-	Temp:	Pulse:	Resp:

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

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 ☐ 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)* ☐ Fluoride Supplement ☐ **Fluoride Varnish by PCP** *(Every 3 months)* Last Dental Appointment:_____ ☐ Future Dental Appointment

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: ☐ 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 ☐ 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/m^2	%

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 *(Appropriate Action to Follow)*

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

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 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 (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: ☐ 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

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/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/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 ☐ 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 (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		

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24, 10/01/25, 10/01/26

Approval Dates: 07/01/01, 06/01/03, 11/01/03, 01/01/04, 11/01/07, 10/01/09, 04/01/14, 10/18/18, 02/21/19, 04/16/20, 10/07/21, 7/14/22,08/17/23, 08/26/24, 09/17/25, 05/15/26

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/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/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 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 (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) ☐ Depression Screen (10 years of age or greater)[3] ☐ SUD Screen (12 years of age) ☐ Other____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)

[3] Added depression screen to align with the AHCCCS EPSDT periodicity schedule. Depression screening starting at years of age.

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 (once between 9-11years of age) [4] ☐ 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:** _____

[4] Added lipid profile to align with the AHCCCS EPSDT periodicity schedule. Dyslipidemia test once between 9-11 years and 17-20 years of age.

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/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/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 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 (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_____

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 ☐ Depression Screen ☐ SUD Screen

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 (once between 17-20years of age) ☐ Syphilis Test (15 years +) ☐
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:* _____
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/m^2	%

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

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

Menses:	Audiometry:	☐ Within
☐ Yes ☐ No		

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

HEALTH RISK ASSESSMENT: ☐ HEADSS ☐ 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 (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 ☐ Depression Screen ☐ SUD Screen

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 (once between 17-20years of age) ☐ 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:** _____