

The Arizona Health Care Cost Containment System (AHCCCS) EPSDT Tracking Forms shall be used by all providers offering care to AHCCCS members under 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, providers 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:

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

Refer to AMPM Chapter 400 for EPSDT responsibilities and services.

Contractors are required to print two-part carbonless EPSDT Tracking Forms (a copy for the member's medical record and a copy for providers to send to the Contractor's MCH/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(s), 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:

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

Contractors and 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. 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.azahcccs.gov.



AHCCCS MEDICAL POLICY MANUAL

**POLICY 430, ATTACHMENT E –
AHCCCS EPSDT TRACKING FORMS**

3-5 DAYS OLD AHCCCS EPSDT TRACKING FORM

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:
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Allergies:	Birth Weight:		Weight:			Length:		Head Circumference:	
	lb	oz	lb	oz	%	cm	%	cm	%

Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown
Second Newborn Hearing Screen (If 2 nd Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> 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

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)

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____



AHCCCS MEDICAL POLICY MANUAL

**POLICY 430, ATTACHMENT E –
AHCCCS EPSDT TRACKING FORMS**

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)		Current Medications/Vitamins/Herbal Supplements:			Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Allergies:		Birth Weight:	Weight:		Length:		Head Circumference:
		lb oz	lb oz	%	cm	%	cm %
Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown							
Second Newborn Hearing Screen (If 2 nd Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> 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 Pacifier Use Bottle Propping Infant Bonding

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)

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____



AHCCCS MEDICAL POLICY MANUAL

**POLICY 430, ATTACHMENT E –
AHCCCS EPSDT TRACKING FORMS**

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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:
Allergies:	Birth Weight:	Weight:		Length:
	lb oz	lb oz	%	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 _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____



AHCCCS MEDICAL POLICY MANUAL

**POLICY 430, ATTACHMENT E –
AHCCCS EPSDT TRACKING FORMS**

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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:		Temp:	Pulse:	Resp:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?

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 _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____



AHCCCS MEDICAL POLICY MANUAL

**POLICY 430, ATTACHMENT E –
AHCCCS EPSDT TRACKING FORMS**

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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:			Temp:	Pulse:	Resp:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?

ERBAL 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 _____

PROVIDER'S SIGNATURE: _____

NPI: _____

Date: _____

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)	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:	Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies:		Birth Weight:	Weight:		Length:
		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?

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

PROVIDER'S SIGNATURE: _____ **NPI:** _____ **Date:** _____

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)		Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:
		lb oz	lb oz %	cm %	cm %
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Automated Device <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unable to Perform

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?

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
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 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 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:		
<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Temp:		Pulse:		Resp:		
Allergies:			Weight:		Length:	
			lb	oz	cm	%
			Head Circumference:		cm	
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Automated Device <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform

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)

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:	<input type="checkbox"/> Blood Lead Testing (Child At Risk/Not already Done at 12 Months) <input type="checkbox"/> Finger Stick (Result: _____) <input type="checkbox"/> Venous <input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Had chicken pox <input type="checkbox"/> Other _____ <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> AzEIP <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> Early Head Start <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> WIC Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____

18 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: (Birth)] Yes] No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:] Yes] No	Temp:	Pulse:	Resp:
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Allergies:	Weight:		Length:		Head Circumference:	
	lb	oz	%	cm	%	cm

Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Automated Device <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform
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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)

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 _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____

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:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temp:		Pulse:		Resp:	
Allergies:		Weight:		Length:	
		lb oz %		cm %	
		Head Circumference:		BMI:	
		cm %		kg/m ² %	
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Automated Device <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer
<input type="checkbox"/> Unable to Perform					

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

BLOOD LEAD LEVEL REQUIRED

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 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: _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
			Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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 ASHS 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: _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
		BMI:		kg/m ² %	
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> <input type="checkbox"/> Refer
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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 _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
Weight:	Height:	BMI:			
		kg/m²	%		
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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:	<input type="checkbox"/> Blood Lead Testing (Child at Risk/Not Already Done at 12/24Months) <input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> Head Start <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> WIC Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____

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:	
				lb / kg	%	cm	%
				BMI:		kg/m²	%
Vision Screening: Record Abnormal Results Below	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer		<input type="checkbox"/> Unable to Perform	
Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal		Age Appropriate Speech:		<input type="checkbox"/> Yes	<input type="checkbox"/> 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)

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:	<input type="checkbox"/> Blood Lead Testing (Child at Risk/Not Already Done at 12/24 Months) <input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____

PROVIDER'S SIGNATURE: _____ **NPI:** _____ **Date:** _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
				BMI:	
				kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Audiometry:	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Abnormal	Age Appropriate Speech:		<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

PROVIDER'S SIGNATURE: _____ **NPI:** _____ **Date:** _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
				BMI:	
				kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Perform <input type="checkbox"/>	
Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal <input type="checkbox"/> Unable to perform		Menses:	Menarche:	LMP:
FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)			<input type="checkbox"/> Yes <input type="checkbox"/> No		

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 _____

PROVIDER'S SIGNATURE: _____ **NPI:** _____ **Date:** _____

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:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
				BMI	
				kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Perform	
Audiometry:	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unable to perform	Menses:	Menarche:
				<input type="checkbox"/> Yes <input type="checkbox"/> No	LMP:
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 Belt/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:	<input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> HepB <input type="checkbox"/> Tdap <input type="checkbox"/> Influenza <input type="checkbox"/> Meningococcal <input type="checkbox"/> HPV <input type="checkbox"/> IPV <input type="checkbox"/> Td <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Other _____ <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> PT <input type="checkbox"/> OB/GYN <input type="checkbox"/> OT <input type="checkbox"/> Speech Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____

18-21 YEARS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Current Medications/Vitamins/Herbal Supplements:	Blood Pressure:	Temp:	Pulse:	Resp:
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Allergies:	Weight:		Height:		BMI	
	lb / kg	%	cm	%	kg/m ²	%

Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
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Audiometry: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal <input type="checkbox"/> Unable to perform	Menses:	Menarche:	LMP:
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FAMILY/SOCIAL HISTORY/CONCERNS: (Current Concerns/ Follow-Up on Previously Identified Concerns)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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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 _____

PROVIDER'S SIGNATURE: _____ **NPI:** _____ **Date:** _____