12 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

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

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