

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: _____