

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	%
				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	
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: TB Skin Test (If at Risk) Hgb/Hct Lipid Profile Other _____

IMMUNIZATIONS ORDERED: HepA MMR Varicella HepB Tdap Influenza Meningococcal HPV IPV Td
 Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental PT OB/GYN OT Speech
 Specialist: Developmental Behavioral Other _____

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