18 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 ☐ 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 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:_____