18-21 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:		BMI	
	lb / kg	%	cm	%	kg/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐Yes ☐No	☐ Unable to Perform

Audiometry:	☐Within Normal Limits	☐Abnormal	☐Unable to perform

Menses:	Menarche:	LMP:
☐ Yes ☐No		

Family/Social History/Concerns: (Current Concerns/ Follow-Up on Previously Identified Concerns)

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: _____

Effective Dates: 03/01/19, 05/07/19, 03/01/19
Approval Dates: 07/01/01, 06/01/03, 11/01/03, 01/01/04, 11/01/07, 10/01/09, 04/01/14, 10/18/18, 02/21/19, 04/16/20