6 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 Screening: Record Abnormal Results Below	Corrected:	Right:	Left:		
	☐ Yes ☐ No	☐ Pass ☐ Refer	☐ Pass ☐ Refer	Both: ☐ Pass ☐ Refer	☐ Unable to Perform

Audiometry:	☐ Within Normal Limits	☐ Abnormal	Age Appropriate Speech:	☐ Yes	☐ No

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

Parental Concerns: How do you feel about your child? Do you feel safe in your home?

Verbal Lead Risk Assessment: Child At Risk ☐ Yes ☐ No (If Yes, Appropriate Action to Follow)

Oral Health: White Spots on Teeth: ☐ Yes ☐ No ☐ Twice Daily Brushing/Flossing (with Parent Assistance) ☐ Sealants ☐ **Fluoride Supplement**
Last Dental Appointment:_____ ☐ Future Dental Appointment Scheduled Dental Home: Provider Name_____

Nutritional Screening: ☐ Nutritionally Balanced Diet/5 Servings Fruits & Veggies ☐ Junk Food ☐ Soda/Juice ☐ Supplements _____
☐ Activity/Family Exercise (1hr/day) ☐ **Overweight** ☐ **Underweight** ☐ Observation ☐ Referral

Developmental Surveillance: ☐ Expressive & Understandable Language ☐ School Attendance ☐ Reading at Grade Level
☐ Follows Simple Directions ☐ Prints Some Letters & Numbers ☐ Balances on One Foot ☐ Other _____

Anticipatory Guidance Provided: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car /Car Seat Safety (Booster Seat) ☐ Safety at Home ☐ Sun Safety ☐ Sport/Helmet Use ☐ Bullying ☐ Street safety
☐ TV Screen Time ☐ Positive Discipline/Redirect ☐ Provide Opportunities for Social Interaction ☐ Age Appropriate Chores
☐ Daily Reading ☐ Other _____

Social-Emotional Health (Observed by clinician/parent report): ☐ Family Adjustment/Parent Responds Positively to Child
☐ Frustration/Impulse Control ☐ Communication/Language ☐ Has Friends ☐ Plays Well with Others/By Self ☐ Feels Capable
☐ Is Liked by Other Children ☐ Expresses Full Range of Emotions ☐ Anger Control ☐ 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** (Child at Risk/Not Already Done at 12/24 Months) ☐ TB Skin Test (If at Risk) ☐ Hgb/Hct ☐ Other _____

Immunizations Ordered: ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ Influenza ☐ Had Chicken Pox
☐ 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 ☐ OT ☐ PT ☐
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