



AHCCCS MEDICAL POLICY MANUAL
POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING
FORMS

7-8 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:	BMI:
			lb / kg	%	cm
				%	kg/m ²
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Audiometry:	Within Normal Limits	Abnormal	Age Appropriate Speech:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing 2x Daily/Flossing Dental Sealants Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Low-Fat Milk Junk Food Soda/Juice
 Supplements _____ Activity/Family Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: School Attendance Reading at Grade Level School Performance IEP/504 Plan
 Discuss Body Changes Has Friends Does Chores When Asked Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sport/Bike Helmet Use Bullying/Fighting
 Street Safety Smoke-Free Environment Positive Discipline Reading Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Frustration /Impulse Control Communication/Language Comfortable Body Image Encourage Independence
 Praise Strengths 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:	<input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Other _____ <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____