9 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:	Birth Weight: lb oz	Weight: lb oz	%	Length: cm	%	Head Circumference: cm	%

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** ☐ **PEDS**

VERBAL LEAD RISK ASSESSMENT: Child At Risk ☐ Yes ☐ No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code ☐ Yes ☐ No

ORAL HEALTH: White Spots on Teeth: ☐ Yes ☐ No ☐ Parent Cleaning Baby's Gums With Infant Toothbrush
☐ Fluoride Supplement ☐ **Fluoride Varnish by PCP** (Once Every 6mo)

NUTRITIONAL SCREENING: ☐ **Breastfeeding** ☐ **Formula** Amount:_____ ☐ **Supplements**:_☐ Vit D ☐ **Receiving WIC Services**
Adequate Weight Gain ☐ Yes ☐ No Plan to Introduce Table Foods_____ ☐ Drinks From Cup ☐ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: ☐ Sits Independently ☐ Pulls to Stand/Cruising ☐ Plays Peek-A-Boo ☐ Uses Words "Mama/Dada"
☐ Waves Bye-Bye ☐ Wary of Strangers ☐ Immature Pincer ☐ Repeats Sounds/Gestures for Attention ☐ Explores Environment ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention
☐ Choking Prevention/Soft Texture Finger Foods ☐ Car/Car Seat Safety (Rear-Facing) ☐ Safe Sleep ☐ Shaken Baby Prevention
☐ Passive Smoke ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Sleep/Wake Cycle ☐ TV Screen Time ☐ Exploration/Learning
☐ Redirection/Positive Parenting ☐ Language/Read to Child/Introduce Board Books ☐ Follow Child's Lead in Play
☐ Parent Communicates to Child "What Things Are" (Ball, Cat, Etc.) ☐ Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child
☐ Appropriate Bonding/Responsive to Needs ☐ Self-Calming ☐ Growing Independence ☐ Shows Preference for Certain People/Toys
☐ Cries When Primary Caregiver Leaves ☐ Postpartum Depression ☐ 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) ☐ Finger Stick (Result:_____) ☐ Venous ☐ Hgb/Hct ☐ Other
IMMUNIZATIONS ORDERED:	☐ HepB ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ 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:_____