# 9-12 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:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

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

**Health Risk Assessment:** ☐ Early Adolescent GAPS (Beginning at 10 Years) ☐ Other _____

**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 of Fruits & Veggies ☐ Junk Food ☐ Soda/ Energy Drinks
☐ Supplements_____ ☐ Activity/Family Exercise (1hr/day) ☐ **Overweight** ☐ **Underweight** ☐ Observation ☐ Referral

**Developmental Surveillance:** ☐School Attendance ☐ Reading at Grade Level ☐ Discuss Body Changes ☐ Dating
☐ Sexuality/Orientation ☐ Performing Well in School ☐Other _____

**Anticipatory Guidance Provided:** ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car/Seat Belt Safety ☐ Safety at Home ☐ Sports/Injury Prevention ☐ Bullying/Violence Prevention ☐ Sun Safety
☐ Safety Rules with Adults ☐ Sex Education/STI ☐ Monitor TV/Computer Time ☐ Peer Refusal Skills ☐Self-Control
☐ Depression/Anxiety ☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐Risks of Tattoos/ Piercing
☐ After-School Activities/Supervision ☐ Educational Goals/Activities ☐ Other _____

**Social-Emotional health (Observed by clinician/parent report):** ☐ Comfortable Body Image ☐ Feels Good About Self
☐ Is Child Happy? ☐ Social Interaction ☐ 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 ☐Other

**Immunizations Ordered:** ☐ Tdap **(11 – 12 Years Only)** ☐ Meningococcal **( 11 – 12 Years Only )** ☐ HPV **( 11 – 12 Years)** ☐ HepA ☐ HepB MMR
☐ Varicella ☐ Td ☐ IPV ☐ 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 ☐ CRS ☐ DDD ☐ Dental ☐ OB/GYN ☐ 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