13 TO 17 YEARS OLD - AHCCCS EPSDT CLINICAL SAMPLE TEMPLATE

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/HEALTH CARE DECISION MAKER CONCERNS: How are you feeling about your teenager? Do you feel safe in your home?

HEALTH RISK ASSESSMENT: ☐ HEADSS ☐ 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 (1 hr/day) ☐ Overweight ☐ Underweight ☐ Observation ☐ Referral

DEVELOPMENTAL SURVEILLANCE: ☐School Attendance ☐Reading at Grade Level ☐ Dating ☐ Sexuality/Orientation
☐Risk-Taking ☐ Other________________________

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Violence Prevention/Gun Safety/Bullying ☐ Drowning/Sun Safety
☐ Car/Seat Beat/Driving Safety ☐ Safety at Home ☐ Sports/Injury prevention ☐ Peer Refusal Skills ☐ Age-Appropriate Limits
☐ Sexual Orientation/Dating ☐ Sex Education/STI/Resources ☐ Availability of Family Planning Services ☐ Social Interaction
☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐ Risks of Tattoos/ Piercing ☐ Educational Goals/Activities ☐ Job/Career Planning
☐ Community Involvement ☐ After-School Activities/Supervision ☐ Other _________________________

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Comfortable Body Image ☐ Mental Health Concerns
☐ Dealing with Stress ☐ Depression/Anxiety ☐ Decision-Making ☐ **Suicide Screen** ☐ 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 ☐ 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 ☐ PT ☐ OT ☐ OB/GYN ☐ Speech Specialist: ☐ Developmental ☐ Behavioral ☐ Other ______________________________________
PROVIDER'S SIGNATURE:	___________________________ NPI:__________________ Date:____________________________