

30 MONTHS 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	Temp:	Pulse:
					Resp:
Allergies:			Weight:		BMI:
			lb / kg	%	kg/m ²
			cm	%	%
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age-Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

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

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow)

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing with help (Twice Daily by Parent) Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses Imaginary Characters/Plays Pretend Puts 3-5 Words Together Points to 6 body parts
 Other people can understand what your child is saying half the time Names Self & Others Begins to Play Interactive Games
 Jumps Up and Down in Place Puts on clothes with help Knows correct animal sound (i.e. cat meows) Washes and dries hands without help Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Sports/Helmet Use TV Screen Time
 Supervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting Preschool
 Provide Opportunities for Fantasy Play/Problem Solving Allow Child to Play Independently/Be Available if Child Seeks You Out
 Encourage Literacy/Daily Reading Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child Manage Anger
 "Monster" Fear Frustration/Hitting/Biting/Impulse Control Separates Easily from Parent Shows Interest in Other Children
 Objects to Major Change in Routine Kind to Animals 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"/> Blood Lead Testing (Child At Risk/Not Already Done at 12/24 Months) <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"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <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"/> ACC <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> Head Start <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> WIC Specialist <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____