

12 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
Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Temp:	Pulse: Resp:
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:
		lb oz	lb oz %	cm %	cm %
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Automated Device <input type="checkbox"/>	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 <input type="checkbox"/> Unable to Perform

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

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

BLOOD LEAD LEVEL REQUIRED ☐ (see below)

ORAL HEALTH: White Spots on Teeth: ☐ Yes ☐ No ☐ Daily Brushing (Twice by Parent) ☐ Fluoride Supplement ☐ Fluoride Varnish by PCP (Every 3 months)

NUTRITIONAL SCREENING: ☐ Breastfeeding ☐ Whole Milk Amount _____ ☐ Milk Intake/Weaning from bottle
Adequate Weight Gain ☐ Solids: _____ ☐ Soda ☐ Juice ☐ Supplements

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-1yr.html> ☐ First Steps ☐
"Mama/Dada" Specific ☐ Uses Single Words ☐ Scribbles ☐ Precise Pincer Grasp ☐ Follows Simple One Step Requests ☐ Looks for Hidden Objects ☐ Extends Arm/Leg for Dressing ☐ Points to Objects

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car/Car Seat Safety (Rear-Facing) ☐ Passive Smoke ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Discipline/Praise
☐ Following Child's Lead in Play ☐ Ignore Tantrums/Give Attention to Positive Behaviors ☐ Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child

☐ Self-Calming ☐ Prefers Primary Caregiver Over All Others ☐ Shy/Anxious with Strangers ☐ Tantrums ☐ 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 ☐ Finger Stick ☐ Venous (Result ____) ☐ Hgb/Hct (Required, If not Done at 9 Months) ☐ TB Skin Test (If at Risk) ☐ Other _____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ 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 ☐ AzEIP ☐ CRS ☐ DDD ☐ Dental ☐ Early Head Start ☐ OT ☐ PT ☐ Speech ☐ WIC Specialist:
☐ Developmental ☐ Behavioral ☐ Other _____

PROVIDER'S

SIGNATURE: _____ NPI: _____ Date: _____