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 _____

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 ☐ Syphilis Test (15 years +) ☐ Other

IMMUNIZATIONS ORDERED: ☐HepA ☐ MMR ☐ Varicella ☐ Hep B ☐ 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:_____

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24
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, 10/07/21, 7/14/22,08/17/23, 08/26/24