

18 TO 21 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
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Audiometry: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal <input type="checkbox"/> Unable to perform	Menses:	Menarche:	LMP:
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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: ☐ Abstract Thinking ☒ School Attendance ☒ Sexuality/Orientation
☐ Physical Growth and Development ☒ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Violence Prevention/Gun Safety/Bullying ☐ Drowning/Sun Safety
☐ Car/Seat Belt/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): ☐ Philosophical/Idealistic ☐ Comfortable Body Image
☐ Self-Confident ☐ Building Intimate/ Complex Relationships ☐ Depression/Anxiety/Sleep Issues ☐ Mood Changes ☐ Suicide Screen
☐ SUD Screen

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 ☐ Refused ☐ Delayed ☐ Deferred Reason: _____
☐ Shot Record Updated/Entered in ASIIS ☐ Importance of Immunizations Discussed ☐ Refusal Form Completed

REFERRALS: ☐ ALTCS ☐ Audiology ☐ CRS ☐ DDD ☐ Dental ☐ OB/GYN ☐ PT ☐ OT ☐ Speech
 Specialist: ☐ Developmental ☐ Behavioral ☐ Other _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____