

**24 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)		Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temp:		Pulse:		Resp:	
Allergies:		Weight:		Length:	
		Head Circumference:		BMI:	
		lb oz		cm %	
		cm %		kg/m <sup>2</sup> %	
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?

**DEVELOPMENTAL SCREENING TOOL COMPLETED:** ☐ ASQ ☐ MCHAT ☐ PEDS

**BLOOD LEAD LEVEL REQUIRED** ☐ (see below)

**ORAL HEALTH:** White Spots on Teeth: ☐ Yes ☐ No ☐ Daily Brushing (Twice Daily by Parent) ☐ Fluoride Supplement ☐ Fluoride Varnish by PCP (Every 3 months)  
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**NUTRITIONAL SCREENING:** ☐ Feeds Self ☐ Nutritionally Balanced Diet ☐ Junk Food ☐ Soda/Juice  
☐ Activity ☐ Supplements ☐ Overweight ☐ Underweight ☐ Observation ☐ Referral

**DEVELOPMENTAL SURVEILLANCE:** <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2yr.html> ☐ Kicks a Ball ☐ Stacks 5-6 Blocks ☐ 50 Word Vocabulary ☐ Walks Upstairs/Runs Well

**ANTICIPATORY GUIDANCE PROVIDED:** ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention  
☐ Car /Car Seat Safety (Forward Facing) ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Trike/Bike Safety (Helmet Use)  
☐ Establish Daily Routine ☐ Discipline/Redirection/Praise ☐ Provide Opportunities for Success/Choice ☐ Praise for Effort/Success  
☐ Encourage/Support Wide Range of Emotions ☐ Read to Child ☐ Other \_\_\_\_\_

**SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):** ☐ Family Adjustment/Parent Responds Positively to Child ☐ Self-Calming ☐ Appropriate Bonding/Responsive to Needs ☐ Frustration/Hitting/Biting/Impulse Control ☐ Communication/Language ☐ Sense of Humor ☐ Demonstrates Increasing Independence ☐ Plays Alongside Peers ☐ Other \_\_\_\_\_

**COMPREHENSIVE PHYSICAL EXAM:**

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

**ASSESSMENT/PLAN/FOLLOW-UP:**

**LABS ORDERED:** ☐ Blood Lead Testing ☐ FingerStick (Result) ☐ Venous ☐ 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:** \_\_\_\_\_