THREE TO FIVE DAYS 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) ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. Ear** ☐ Pass ☐ Refer ☐ Unknown
Second Newborn Hearing Screen (If 2nd Needed/Completed): ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. Ear** ☐ Pass ☐ Refer ☐ Unknown

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?

ORAL HEALTH: ☐ Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: ☐ Breastfeeding Frequency/Duration:_____ ☐ Supplements:_____ ☐ Vit D ☐ Formula Type:_____ Amount/Duration:_____ Adequate Weight Gain ☐ Yes ☐ No ☐ Receiving WIC Services

DEVELOPMENTAL SURVEILLANCE: ☐ Rooting Reflex ☐ Startle ☐ Suck & Swallow ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention ☐ Car/Car Seat Safety (Rear-Facing) ☐ Safe Sleep ☐ Shaken Baby Prevention ☐ Safe Bathing/Water Temperature ☐ Passive Smoke ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Pacifier Use ☐ Bottle Propping ☐ Infant Bonding ☐ Support Systems/Resources ☐ Infant Crying/Appropriate Interventions ☐ Other: _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child ☐ Appropriate Bonding/Responsive to Needs ☐ Infant Hands to Mouth/Self-Calming ☐ Postpartum Depression Screen ☐ 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: ☐ 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit) ☐ Other _____

IMMUNIZATIONS ORDERED: **DATE 1ST HEP B ADMINISTERED:**_____ ☐ Hep B (Not Previously Administered) ☐ 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_____ ☐ 2nd Newborn Hearing Screen (If Needed)

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

Effective Dates: 03/01/19, 05/07/19, 02/01/22, 10/01/22, 11/28/23, 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, 10/07/21, 07/14/22, 08/17/23, 08/26/24