# 24 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

| 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: | Risk Indicators of Hearing Loss: ☐Yes ☐No | Temp: | Pulse: | Resp: |
|---|---|---|---|---|---|
| | | | | | |

| Allergies: | Weight: | | Length: | | Head Circumference: | | BMI: | |
|---|---|---|---|---|---|---|---|---|
| | lb oz | % | cm | % | cm | % | kg/m² | % |
| | | | | | | | | |

| Vision Screening: | Corrected: ☐Yes ☐No | Automated Device ☐ | Right: ☐Pass ☐Refer | Left: ☐Pass ☐Refer | Both: ☐Pass ☐Refer | ☐Unable to Perform |
|---|---|---|---|---|---|---|
| | | | | | | |

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

**PARENTAL 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**

**ORAL HEALTH:** White Spots on Teeth: ☐Yes ☐No ☐Daily Brushing (Twice Daily by Parent) ☐**Fluoride Supplement**
First Dental Appointment ☐Completed ☐Scheduled Dental Home: Provider Name_____

**NUTRITIONAL SCREENING:** ☐Feeds Self ☐Nutritionally Balanced Diet ☐Junk Food ☐Soda/Juice
☐Activity ☐Supplements_____ ☐**Overweight** ☐**Underweight** ☐Observation ☐Referral

**DEVELOPMENTAL SURVEILLANCE:** ☐Kicks a Ball ☐Stacks 5-6 Blocks ☐50 Word Vocabulary ☐Walks Upstairs/Runs Well
☐Put Two Words Together ☐Jumps Up ☐Follows Two Step Commands ☐Other _____

**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
☐Appropriate Bonding/Responsive to Needs ☐Self-Calming ☐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** ☐Finger Stick (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:_____