ONE MONTH 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: ☐ Responds to Sounds ☐ Responds to Parent's Voice ☐Follows With Eyes to Midline
☐Awake For 1 Hour Stretches ☐ Beginning Tummy Time https://www.cdc.gov/ncbddd/actearly/milestones/index.html

☐ 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
☐Infant Hands to Mouth/Self-Calming ☐ Appropriate Bonding/Responsive to Needs ☐ **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 ☐
☐ Results of 2nd AZ Newborn Screening Received (If No, What Follow Up Taken:)

IMMUNIZATIONS **DATE 1st HEP B/2nd 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
_____ NPI:_____ Date:_____

Effective Dates: 03/01/19, 05/07/19, 02/01/22, 10/01/22, 11/28/23
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