

13 TO 17 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	Unable to Perform
--------------------	-------	------	------	--	-------------------

Audiometry: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal <input type="checkbox"/> Unable to perform	Menses:	Menarche:	LMP:
--	---------	-----------	------

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
--	--	--	--

PARENTAL/HEALTH CARE DECISION MAKER CONCERNS: How are you feeling about your teenager? Do you feel safe in your home?

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: School Attendance Reading at Grade Level Dating Sexuality/Orientation
 Risk-Taking 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): Comfortable Body Image Mental Health Concerns
 Dealing with Stress Depression/Anxiety Decision-Making Suicide Screen SUD Screen Other _____

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 Other _____

IMMUNIZATIONS ORDERED: HepA MMR Varicella Hep B Tdap Influenza Meningococcal HPV IPV Td 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 CRS DDD Dental PT OT OB/GYN Speech Specialist: Developmental
 Behavioral Other _____

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