FOUR 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) ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

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

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**
☐ Cereal Type:_____ ☐ Plan to Introduce Solids_____ ☐ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4mo.html
☐ Babbles and Coos ☐ Laughs ☐ Begins to Roll Front to Back ☐ Pushes Up with Arms
☐ Controls Head Well ☐ Reaches for Objects ☐ Interest in Mirror Images ☐ Pushes Down with Legs When Feet on Surface

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 ☐ Bottle Propping ☐ Support Systems/Resources
☐ Infant Crying/Appropriate Interventions ☐ Discuss Child Temperament ☐ Establish Daily Routines/Infant Regulation
☐ Establish Nighttime Sleep Routine/Sleep Through Night (Greater 5 hours) ☐ Parent Reads to Child ☐ Other _____

SOCIAL-EMOTIONAL HEALTH AND (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Baby
☐ Infant Hands to Mouth/Self-Calming ☐ Smiles When Hears Parents' Voices ☐ Appropriate Bonding/Responsive to Needs
☐ Easily Distracted/Excited by Discovery of Outside World ☐ **Postpartum Depression Screen** ☐ other

COMPREHENSIVE PHYSICAL EXAM:

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

ASSESSMENT/PLAN/FOLLOW-UP

LABS ORDERED:	☐ Other _____
IMMUNIZATIONS ORDERED:	☐ HepB ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ 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:_____

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