

**FOUR YEARS OLD - AHCCCS EPSDT CLINICAL SAMPLE TEMPLATE**

<b>Date</b>	<b>Last Name</b>	<b>First Name</b>	<b>AHCCCS ID #</b>	<b>DOB</b>
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<b>Age</b>	<b>Primary Care Provider</b>	<b>PCP ph. #</b>	<b>Health Plan</b>	<b>Accompanied By (Name)</b>	<b>Relationship</b>
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<b>Current Medications/Vitamins/Herbal Supplements:</b>	<b>Blood Pressure:</b>	<b>Temp:</b>	<b>Pulse:</b>	<b>Resp:</b>
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<b>Allergies:</b>	<b>Weight:</b>		<b>Height:</b>		<b>BMI:</b>	
	lb / kg	%	cm	%	kg/m <sup>2</sup>	%

<b>Vision Screening:</b>	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart <input type="checkbox"/>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer
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<b>Hearing Screening:</b>	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	<b>Age-Appropriate Speech:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

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

**VERBAL LEAD RISK ASSESSMENT:** Child At Risk  Yes  No (Appropriate Action to Follow)

**ORAL HEALTH:** White Spots on Teeth:  Yes  No     Daily Brushing (Twice Daily by Parent)     Fluoride Supplement  
 Fluoride Varnish by PCP

**NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet  Junk Food  Soda/Juice  Supplements  Activity/Family Exercise  
 Overweight  Underweight  Observation  Referral

**DEVELOPMENTAL SURVEILLANCE:** <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4yr.html>  Sings a Song  Draws a Person with 3 Parts  Names Self & Others  Names 4 Colors/3 Shapes  Counts 1-7 Objects Out Loud (Not Always in Order)  Shows Interest in Other Children  Dresses Self  Brushes Own Teeth

**ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention  Sun Safety  
 Car /Car Seat Safety (Forward Facing)  Safety at Home/Child-Proofing  Sports/Helmet Use  Good and Bad Touches  Positive Discipline / Redirect  Reading/Preschool  School Readiness  Allow Child to Play Independently/be Available if Child Seeks You Out  Other

**SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child  
 Self-Calming  Separates Easily from Parent  Kind to Animals  Objects to Major Change in Routine  Has Words for Feelings  
 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:**  Blood Lead Testing (Child at Risk/Not Already Done at 12/24 Months)  TB Skin Test (If at Risk)  Hgb/Hct  Other \_\_\_\_\_

**IMMUNIZATIONS ORDERED:**  HepA  HepB  MMR  Varicella  DTaP  Hib  IPV  PCV  Influenza  Had Chicken Pox  
 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  Head Start  OT  PT  Speech  WIC  
 Specialist:  Developmental  Behavioral  Other \_\_\_\_\_

**PROVIDER'S SIGNATURE:** \_\_\_\_\_ NPI: \_\_\_\_\_ Date: \_\_\_\_\_