

SIX 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 Screening: Record	Corrected:	Right:	Left:	Both:	Unable to Perform
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Pass <input type="checkbox"/> Refer	

Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal	Age-Appropriate Speech:	<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 DO YOU FEEL ABOUT YOUR CHILD? DO YOU FEEL SAFE IN YOUR HOME?

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

ORAL HEALTH: White Spots on Teeth: Yes No Twice Daily Brushing/Flossing (with Parent Assistance) Sealants Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise (1 hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Expressive & Understandable Language School Attendance Reading at Grade Level
 Follows Simple Directions Prints Some Letters & Numbers Balances on One Foot Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sport/Helmet Use Bullying Street safety
 TV Screen Time Positive Discipline/Redirect Provide Opportunities for Social Interaction Age Appropriate Chores
 Daily Reading Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Frustration/Impulse Control Communication/Language Has Friends Plays Well with Others/By Self Feels Capable
 Is Liked by Other Children Expresses Full Range of Emotions Anger Control 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 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

REFERRALS: ALTCS Audiology CRS DDD Dental OT PT Speech Specialist Developmental
 Behavioral Other _____

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