NINE TO TWELVE 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 ☐ Yes ☐ No ☐ Unable to

Audiometry: ☐Within Normal Limits ☐Abnormal ☐Unable to perform

Menses:	Menarche:	LMP:
☐ Yes ☐ No		

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?

HEALTH RISK ASSESSMENT: ☐ Early Adolescent GAPS (Beginning at 10 Years) ☐ Other ______________________________

ORAL HEALTH: White Spots on Teeth: ☐ Yes ☐ No ☐Daily Brushing 2x Daily/Flossing ☐ Dental Sealants ☐ 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/Family Exercise (1 hr/day) ☐ Overweight ☐ Underweight ☐ Observation ☐ Referral

DEVELOPMENTAL SURVEILLANCE: ☐ School Attendance ☐ Reading at Grade Level ☐ Discuss Body Changes ☐ Dating
☐Sexuality/Orientation ☐ Performing Well in School ☐Other ____________________

ANTICIPATORY GUIDANCE PROVIDED: ☐Emergency/911 ☐Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐Car/Seat Belt Safety ☐ Safety at Home ☐ Sports/Injury Prevention ☐ Bullying/Violence Prevention ☐ Sun Safety
☐Safety Rules with Adults ☐Sex Education/STI ☐Monitor TV/Computer Time ☐Peer Refusal Skills ☐Self-Control
☐Depression/Anxiety ☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐Risks of Tattoos/ Piercing
☐After-School Activities/Supervision ☐ Educational Goals/Activities ☐ Other_________________

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Comfortable Body Image ☐ Feels Good About Self
☐ Is Child Happy? ☐ Social Interaction ☐ **Suicide Screen (10 years of age or greater)** ☐ 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 ☐Other
IMMUNIZATIONS ORDERED:	☐ Tdap **(11 – 12 Years)** ☐ Meningococcal **(11 – 12 Years)** ☐ HPV **(11 – 12 Years)** ☐ HepA ☐ HepB ☐MMR ☐Varicella ☐ Td ☐ IPV ☐ Influenza ☐ 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 ☐ OB/GYN ☐ OT ☐ PT ☐ Speech Specialist: ☐ Developmental ☐ Behavioral ☐ Other ______________________________
PROVIDER'S SIGNATURE:	___________________________ NPI:__________________ DATE:____________________________

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 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, 04/16/20, 10/07/21, 7/14/22