

THREE TO FIVE DAYS 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:				
Allergies:	Birth Weight:		Weight:		Length:		Head Circumference:	
	lb	oz	lb	oz	%	cm	%	cm
Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown								
Second Newborn Hearing Screen (if 2nd Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown								

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

DEVELOPMENTAL SURVEILLANCE: Rooting Reflex Startle Suck & Swallow Other _____

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 Pacifier Use Bottle Propping Infant Bonding Support Systems/Resources

Infant Crying/Appropriate Interventions Other: _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively

to Child Appropriate Bonding/Responsive to Needs Infant Hands to Mouth/Self-Calming Postpartum Depression Screen

Other _____

COMPREHENSIVE PHYSICAL EXAM:

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

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit) Other _____

IMMUNIZATIONS DATE 1ST HEP B ADMINISTERED: _____ Hep B (Not Previously Administered) Other _____

ORDERED: 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 _____ 2nd Newborn Hearing Screen (If Needed)

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