

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 | % |
| Vision Screening: Record Abnormal Results Below | | | Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No | 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 <input type="checkbox"/> Unable to Perform |
| Audiometry: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal | | | Age-Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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 for under 4'9" height) 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

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: _____