

FIVE 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:	
			lb / kg	%	cm	%
			BMI:		kg/m ²	
Vision Screening:	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	
Hearing Screening:	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	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 (Appropriate Action to Follow)

ORAL HEALTH: White Spots on Teeth: Yes No Twice Daily Brushing/Flossing (With Parent Assistance) 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 (1hr/day) **Overweight** **Underweight** Observation Referral

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-5yr.html> Uses Imaginary Characters

Matches Colors & Shapes/Prints Some Numbers and Letters Counts to 10 Follows Simple Directions Listens and Attends Can Button

& Zip Clothing Independently Goes to Bathroom Independently Holds Pencil/Cuts with Scissors Cooperates More in Group Setting

Good Articulation/Language Skills Hops/Skips 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 Sports/Helmet Use Bullying Good and Bad Touches TV Screen Time Begins to Agree with Rules Dictates Story to Adults Listens to Authority Figure & Follows Instructions

School Readiness Communication with Teachers Other _____

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

tively to Child Self-Calming Wants to Please & Be with Friends Shows Empathy for Others Positive about Self & Abilities

Tells Stories of Convenience (Lying) 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 Completed

REFERRALS: ALTCS Audiology CRS DDD Dental Head Start OT PT Speech WIC Specialist:

Developmental Behavioral Other _____

PROVIDER’S SIGNATURE: _____ **NPI:** _____ **DATE:** _____