

**FOUR 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	%
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 are you feeling about 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  Daily Brushing (Twice Daily by Parent)  Fluoride Supplement  
 Fluoride Varnish by PCP (Every 3 months)

**NUTRITIONAL SCREENING:**  Nutritionally Balanced Diet  Junk Food  Soda/Juice  Supplements  Activity/Family Exercise  
 Overweight  Underweight  Observation  Referral

**DEVELOPMENTAL SURVEILLANCE:** <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4yr.html>  Sings a Song  Draws a Person with 3 Parts  Names Self & Others  Names 4 Colors/3 Shapes  Counts 1-7 Objects Out Loud (Not Always in Order)  Shows Interest in Other Children  Dresses Self  Brushes Own Teeth

**ANTICIPATORY GUIDANCE PROVIDED:**  Emergency/911  Gun Safety  Drowning Prevention  Choking Prevention  Sun Safety  
 Car /Car Seat Safety (Forward Facing)  Safety at Home/Child-Proofing  Sports/Helmet Use  Good and Bad Touches  Positive Discipline / Redirect  Reading/Preschool  School Readiness  Allow Child to Play Independently/be Available if Child Seeks You Out  
 Other

**SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):**  Family Adjustment/Parent Responds Positively to Child  
 Self-Calming  Separates Easily from Parent  Kind to Animals  Objects to Major Change in Routine  Has Words for Feelings  
 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**

<b>LABS ORDERED:</b>	<input type="checkbox"/> Blood Lead Testing (Child at Risk/Not Already Done at 12/24 Months) <input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Other _____
<b>IMMUNIZATIONS ORDERED:</b>	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> DTaP <input type="checkbox"/> Hib <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
<b>REFERRALS:</b>	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> Head Start <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> WIC Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____
<b>PROVIDER'S SIGNATURE:</b>	_____ NPI: _____ Date: _____