ONE MONTH 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)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. ear** ☐ Pass ☐ Refer ☐ Unknown

Second Newborn Hearing Screen (If 2nd Needed/Completed): ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. Ear** ☐ Pass ☐ Refer ☐ 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: ☐ Responds to Sounds ☐ Responds to Parent's Voice ☐ Follows With Eyes to Midline

☐ Awake For 1 Hour Stretches ☐ Beginning Tummy Time ☐ 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 ☐ Infant Hands to Mouth/Self-Calming ☐ Appropriate Bonding/Responsive to Needs ☐ Postpartum Depression Screen

☐ Other _____

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24, 10/01/25

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, 7/14/22,08/17/23, 08/26/24, 09/17/25

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 _____

☐ Results of 2nd AZ Newborn Screening Received *(If No, What Follow Up Taken:*)

IMMUNIZATIONS ORDERED: **DATE 1st HEP B/2nd HEP B ADMINISTERED:**_____/_____☐ Hep B (Not Previously Administered) ☐ 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 ☐ 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:** _____

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 10/01/24, 10/01/25
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, 7/14/22,08/17/23, 08/26/24, 09/17/25