

NINE MONTHS 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)		Current Medications/Vitamins/Herbal Supplements:				Risk Indicators of Hearing		Temp:	Pulse:	Resp:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No					<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Allergies:			Birth Weight:		Weight:		Length:		Head Circumfer-		
			lb	oz	lb	oz	%	cm	%	cm	%

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?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ PEDS

VERBAL LEAD RISK ASSESSMENT: Child at Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High-Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Parent Cleaning Baby's Gums with Infant Toothbrush Fluoride Supplement
 Fluoride Varnish by PCP (every 3 months)

NUTRITIONAL SCREENING: Breastfeeding Formula Amount: _____ Supplements: _____ Vit D

Receiving WIC Services Adequate Weight Gain Yes No Plan to Introduce Table Foods _____ Drinks from Cup

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-9mo.html> Sits Independently

Pulls to Stand/Cruising Plays Peek-A-Boo Uses Words "Mama/Dada" Waves Bye-Bye Wary of Strangers Immature Pincer

Repeats Sounds/Gestures for Attention Explores Environment Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Safe Sleep Shaken Baby

Prevention Choking Prevention/Soft Texture Finger Foods Car/Car Seat Safety (Rear-Facing) Passive Smoke Sun Safety

Safety at Home/Childproofing Sleep/Wake Cycle TV Screen Time Exploration/Learning Redirection/Positive Parent

Language/Read to Child/Introduce Board Books Follow Child's Lead in Play Parent Communicates to Child "What Things Are" (Ball, Cat, Etc.) Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Posi-
tively to Child Appropriate Bonding/Responsive to Needs Self-Calming Growing Independence Shows Preference for Certain Peo-
ple/Toys Cries When Primary Caregiver Leaves Postpartum Depression 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 Led Testing (Child at Risk) Finger Stick (Result: _____) Venous Hgb/Hct
 Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Influenza 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 _____

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