

SEVEN TO EIGHT 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	%	kg/m ²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<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?

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing 2x Daily/Flossing Dental Sealants Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Low-Fat Milk Junk Food Soda/Juice
 Supplements _____ Activity/Family Exercise (1 hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: School Attendance Reading at Grade Level School Performance IEP/504 Plan
 Discuss Body Changes Has Friends Does Chores When Asked 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/Bike Helmet Use
 Bullying/Fighting

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Frustration /Impulse Control Communication/Language Comfortable Body Image Encourage Independence
 Praise Strengths 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: TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella Td IPV Influenza Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____

REFERRALS: ALTCS Audiology CRS DDD Dental OT PT
 Speech Specialist: Developmental Behavioral Other _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____