

18 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) <input type="checkbox"/> Yes <input type="checkbox"/> No | Current Medications/Vitamins/Herbal Supplements: | Risk Indicators of Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No | | Temp: | Pulse: | Resp: |
| Allergies: | | | Weight: lb oz % | Length: cm % | Head Circumference: cm % | |
| Vision Screening: | Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No | Automated Device <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 | <input type="checkbox"/> Unable to Perform |

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 MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: Child at Risk Yes No (If Yes, 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) First Dental Appointment Completed Scheduled Dental Home Provider: _____

NUTRITIONAL SCREENING: Feeds Self Breastfeeding Whole Milk Nutritionally Balanced Diet Junk Food Soda/Juice

Solids Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-18mo.html> Uses a cup Walks

Says 10-20 Words Says "No" Name One Picture/2 Colors Follows Simple Rules/Bring Me the Book Knows Animal Sounds

Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning prevention Choking Prevention

Car/Car Seat Safety (Rear-Facing) Safety at Home/Child-Proofing Sun Safety Helmet Use Never Leave Toddler Alone

Sibling Interaction Discipline/Limits Growing Independence Encourage Expression of Wide Range of Emotions Read to Child

Other _____

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

tively to Child Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control

Communication/Language Demonstrates Increasing Independence Defiant Behavior/Offer Child Choices Other _____

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: Blood Lead Testing (*Child at Risk/Not already Done at 12 Months*) Finger Stick (*Result: _____*) Venous

TB Skin Test (*If at Risk*) Other _____

IMMUNIZATIONS HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza

ORDERED: Had chicken pox 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:** _____