

THREE 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	Temp:	Pulse:	Resp:		
Allergies:				Weight:		Height:		BMI:	
				lb / kg	%	cm	%	kg/m ²	%
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart	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 your child? Do you feel safe in your home?

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
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

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-3yr.html> Uses Imaginary Characters Matches Colors and Shapes Counts to 5 Knows Gender

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 TV Screen Time Preschool
 Supervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting Encourage Literacy
 Provide Opportunities for Fantasy Play/Problem Solving 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
 Manage Anger "Monster" Fear Frustration/Hitting/Biting/Impulse Control Separates Easily from Parent
 Objects to Major Change in Routine Shows Interest in Other Children Kind to Animals 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:	<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 _____
IMMUNIZATIONS ORDERED:	<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
REFERRALS	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> ACC <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 _____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____