

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:		Temp:	Pulse:
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:
		lb oz	lb oz %	cm %	cm %
Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown					
Second Newborn Hearing Screen (If 2 <sup>nd</sup> Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown					

**FAMILY/SOCIAL HISTORY:** (Current Concerns/ Follow-Up on Previously Identified Concerns)

**PARENTAL 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  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  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:**  2<sup>nd</sup> Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit)  Other \_\_\_\_\_  
 Results of 2<sup>nd</sup> AZ Newborn Screening Received (If No, What Follow Up Taken: \_\_\_\_\_)

**IMMUNIZATIONS ORDERED:** DATE 1<sup>ST</sup> HEPB/2<sup>ND</sup> HEPB ADMINISTERED: \_\_\_\_\_ / \_\_\_\_\_  HepB (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 \_\_\_\_\_  2<sup>nd</sup> Newborn Hearing Screen (If Needed)

\_\_\_\_\_  
Date/Time      Clinician Name (Print)      Clinician Signature      NPI #      See Additional Supervisory Note  Yes  No