3 Years Old — AHCCCS EPSDT Tracking Form

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 ☐ Yes ☐ No	☐ Unable to Perform

Hearing Screening:	Right ☐ Pass ☐ Refer	Left ☐ Pass ☐ Refer	☐ Unable to Perform	Age Appropriate Speech: ☐ Yes ☐ No

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

PARENTAL 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)* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

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: ☐ Uses Imaginary Characters ☐ Matches Colors and Shapes ☐ Counts to 5 ☐ Knows Gender
☐ Names Self & Others ☐ Begins to Play Interactive Games ☐ Stand on One Foot ☐ Communication/Language ☐ Other_____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car /Car Seat Safety *(Forward Facing)* ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Sports/Helmet Use ☐ TV Screen Time
☐ Supervise Outdoor Play ☐ Positive Discipline/Redirect/Reinforce Limits ☐ Establish Routine for: Bed/Meals/Toileting ☐ Preschool
☐ Provide Opportunities for Fantasy Play/Problem Solving ☐ Allow Child to Play Independently/Be Available if Child Seeks You Out
☐ Encourage Literacy ☐ 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: ☐ **Blood Lead Testing** *(Child at Risk/Not Already Done at 12/24Months)* ☐ TB Skin Test *(If at Risk)* ☐ Hgb/Hct ☐ Other ____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Had Chicken Pox
☐ 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 ☐ CRS ☐ DDD ☐ Dental ☐ Head Start ☐ OT ☐ PT ☐ Speech ☐ WIC
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* _____

Date/Time _____ Clinician Name (Print) _____ Clinician Signature _____ NPI # _____ See Additional Supervisory Note ☐ **Yes** ☐ **No**