3-5 Days 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

Admitted to NICU: *(Birth)* ☐ Yes ☐ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. Ear** ☐ Pass ☐ Refer ☐ Unknown
Second Newborn Hearing Screen *(If 2nd Needed/Completed):* ☐ ABR ☐ OAE: **Rt. Ear** ☐ Pass ☐ Refer **Lt. Ear** ☐ Pass ☐ Refer ☐ 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: ☐ Rooting Reflex ☐ Startle ☐ Suck & Swallow ☐ 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 ☐ Pacifier Use ☐ 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
☐ Appropriate Bonding/Responsive to Needs ☐ Infant Hands to Mouth/Self-Calming ☐ Baby Blues/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: ☐ 2nd Arizona Newborn Screening Bloodspot Test *(5 – 10 Days of Age or First PCP Visit)* ☐ Other _____

IMMUNIZATIONS ORDERED: **DATE 1ST 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* _____ ☐ 2nd Newborn Hearing Screen *(If Needed)*

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