4 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: lb / kg	Weight: %	Height: cm	Height: %	BMI: kg/m²	BMI: %

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 child? Do you feel safe in your home?*

VERBAL LEAD RISK ASSESSMENT: Child At Risk ☐ *Yes* ☐ *No (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: ☐ Sings a Song ☐ Draws a Person with 3 Parts ☐ Names Self & Others ☐ Names 4 Colors/3 Shapes
☐ Counts 1-7 Objects Out Loud (Not Always in Order) ☐ Shows Interest in Other Children ☐ Dresses Self ☐ Brushes Own Teeth
☐ Asks/Answers - Who, What, Where, Why ☐ Follows 2 Unrelated Directions ☐ Balances/Hops on One Foot ☐ 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 ☐ Good and Bad Touches
☐ Positive Discipline/Redirect ☐ Reading/Preschool ☐ School Readiness
☐ 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
☐ Self-Calming ☐ Separates Easily from Parent ☐ Kind to Animals ☐ Objects to Major Change in Routine ☐ Has Words for Feelings
☐ 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**