

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	

Admitted to NICU: (Birth)	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:	Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies:	Birth Weight:	Weight:	Length:		Head Circumference:
	lb oz	lb oz %	cm %	cm %	

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?

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: Parent Cleaning Baby's Gums With Washcloth/Infant Toothbrush Fluoride Supplement Fluoride Varnish by PCP

NUTRITIONAL SCREENING: Breastfeeding Frequency/Duration: _____ Supplements: _____ Vit D
 Formula Type: _____ Amount/Duration: _____ Adequate Weight Gain Yes No Receiving WIC Services
 Cereal Type: _____ Plan to Introduce Solids _____ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: Using A String of Vowels Rolls Over Transfers Small Objects Vocal Imitation
 Sits With Support Explores With Hands and Mouth Peek-a-Boo/Patty Cake Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention Passive Smoke Safety at Home/Child-Proofing
 Sun Safety Refrain From Jump Seat/Walker Sleep/Wake Cycle Introduce Cup Begin Using High Chair
 Wary of Strangers Introduce Board Books Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Baby
 Appropriate Bonding/Responsive to Needs Recognizes Familiar People Distinguishes Emotions by Tone of Voice
 Self-Calming Enjoys Social Play Postpartum Depression 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) Finger Stick (Result: ____) Venous Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Influenza Rotavirus 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 _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note <input type="checkbox"/> Yes <input type="checkbox"/> No
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