7-8 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

Audiometry: ☐ Within Normal Limits ☐ Abnormal	Age Appropriate Speech: ☐ Yes ☐ No

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

PARENTAL CONCERNS: *How do you feel about your child? Do you feel safe in your home?*

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing 2x Daily/Flossing ☐ Dental Sealants ☐ **Fluoride Supplement**
Last Dental Appointment: _____ ☐ Future Dental Appointment Scheduled Dental Home: Provider Name_____

NUTRITIONAL SCREENING: ☐ Nutritionally Balanced Diet/5 Servings Fruits & Veggies ☐ Low-Fat Milk ☐ Junk Food ☐ Soda/Juice
☐ Supplements _____ ☐ Activity/Family Exercise (1hr/day) ☐ **Overweight** ☐ **Underweight** ☐ *Observation* ☐ *Referral*

DEVELOPMENTAL SURVEILLANCE: ☐ School Attendance ☐ Reading at Grade Level ☐ School Performance ☐ IEP/504 Plan
☐ Discuss Body Changes ☐ Has Friends ☐ Does Chores When Asked ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car /Car Seat Safety *(Booster Seat)* ☐ Safety at Home ☐ Sun Safety ☐ Sport/Bike Helmet Use ☐ Bullying/Fighting
☐ Street Safety ☐ Smoke-Free Environment ☐ Positive Discipline ☐ Reading ☐ Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child
☐ Frustration /Impulse Control ☐ Communication/Language ☐ Comfortable Body Image ☐ Encourage Independence
☐ Praise Strengths ☐ 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: ☐ TB Skin Test *(If at Risk)* ☐ Hgb/Hct ☐ Other _____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ Td ☐ IPV ☐ Influenza ☐ Had Chicken Pox ☐ 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 ☐ CRS ☐ DDD ☐ Dental ☐ OT ☐ PT ☐ Speech
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* _____

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