9-12 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 ☐ Unable to perform

Menses:	Menarche:	LMP:
☐ 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?*

HEALTH RISK ASSESSMENT: ☐ Early Adolescent GAPS *(Beginning at 10 Years)* ☐ Other ____________________________________

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 of Fruits & Veggies ☐ Junk Food ☐ Soda/ Energy Drinks
☐ Supplements ________________ ☐ Activity/Family Exercise (1hr/day) **☐ Overweight ☐ Underweight** ☐ *Observation* ☐ *Referral*

DEVELOPMENTAL SURVEILLANCE: ☐ School Attendance ☐ Reading at Grade Level ☐ Discuss Body Changes ☐ Dating
☐ Sexuality/Orientation ☐ Performing Well in School ☐ Other ______________________

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car/Seat Belt Safety ☐ Safety at Home ☐ Sports/Injury Prevention ☐ Bullying /Violence Prevention ☐ Sun Safety
☐ Safety Rules with Adults ☐ Sex Education/STI ☐ Monitor TV/Computer Time ☐ Peer Refusal Skills ☐ Self-Control
☐ Depression/Anxiety ☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐ Risks of Tattoos/ Piercing
☐ After-School Activities/Supervision ☐ Educational Goals/Activities ☐ Other _________________

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Comfortable Body Image ☐ Feels Good About Self
☐ Is Child Happy? ☐ Social Interaction ☐ Other ________________

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner Stage_____**		
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: ☐ Tdap **(11 – 12 Years Only)** ☐ Meningococcal **(11 – 12 Years Only)** ☐ HPV **(11 – 12 Years)** ☐ 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 ☐ OB/GYN ☐ OT ☐ PT ☐ Speech
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* ____

__________ Date/Time ______________________ Clinician Name (Print) ______________________ Clinician Signature ______________ NPI #

See Additional Supervisory Note ☐ **Yes** ☐ **No**

Revised 04/01/2014