12 Months 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:	Risk Indicators of Hearing Loss: ☐ Yes ☐ No	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: 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: ***(Blood Lead Test Required)*** Child At Risk ☐ *Yes* ☐ *No* Lives in High Risk Zip Code ☐ *Yes* ☐ *No*

ORAL HEALTH: White Spots on Teeth: ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice by Parent)* ☐ Fluoride Supplement ☐ **Fluoride Varnish by PCP**
First Dental Appointment ☐ *Completed* ☐ *Scheduled* Dental Home: Provider Name_____ *(Once Every 6mo)*

NUTRITIONAL SCREENING: ☐ Breastfeeding ☐ Whole Milk *Amount* _____ ☐ Milk Intake/Weaning
☐ Adequate Weight Gain ☐ Solids: _____ ☐ Soda ☐ Juice ☐ Supplements

DEVELOPMENTAL SURVEILLANCE: ☐ First Steps ☐ "Mama/Dada" Specific ☐ Uses Single Words ☐ Scribbles ☐ Precise Pincer Grasp
☐ Follows Simple One Step Requests ☐ Looks for Hidden Objects ☐ Extends Arm/Leg for Dressing ☐ Points to Objects
☐ Plays: Hides Object/Pushes Ball Back and Forth ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car/Car Seat Safety*(Rear-Facing)* ☐ Passive Smoke ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Discipline/Praise
☐ Following Child's Lead in Play ☐ Ignore Tantrums/Give Attention to Positive Behaviors ☐ Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child
☐ Self-Calming ☐ Prefers Primary Caregiver Over All Others ☐ Shy/Anxious With Strangers ☐ Tantrums ☐ 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** *(Required)* ☐ Hgb/Hct *(Required, If not Done at 9 Months)* ☐ TB Skin Test *(If at Risk)* ☐ Other ____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ 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 ☐ 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 ☐ **Yes** ☐ **No**