13-17 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/m^2	BMI: %

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 are you feeling about your teenager? Do you feel safe in your home?*

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other _____

ORAL HEALTH: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing 2x Daily/Flossing ☐ **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/Exercise (1hr/day) ☐ **Overweight** ☐ **Underweight** ☐ *Observation* ☐ *Referral*

DEVELOPMENTAL SURVEILLANCE: ☐ School Attendance ☐ Reading at Grade Level ☐ Dating ☐ Sexuality/Orientation
☐ Risk-Taking ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Violence Prevention/Gun Safety/Bullying ☐ Drowning/Sun Safety
☐ Car/Seat Beat/Driving Safety ☐ Safety at Home ☐ Sports/Injury prevention ☐ Peer Refusal Skills ☐ Age Appropriate Limits
☐ Sexual Orientation/Dating ☐ Sex Education/STI/Resources ☐ Availability of Family Planning Services ☐ Social Interaction
☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐ Risks of Tattoos/ Piercing ☐ Educational Goals/Activities ☐ Job/Career Planning
☐ Community Involvement ☐ After-School Activities/Supervision ☐ Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Comfortable Body Image ☐ Mental Health Concerns
☐ Dealing with Stress ☐ Depression/Anxiety ☐ Decision-Making ☐ 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 ☐ Lipid Profile ☐ Other _____

IMMUNIZATIONS ORDERED: ☐ HepA ☐ MMR ☐ Varicella ☐ HepB ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td
☐ 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 ☐ PT ☐ OB/GYN ☐ OT ☐ Speech
Specialist: ☐ *Developmental* ☐ *Behavioral* ☐ *Other* _____

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