15 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:	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 child? 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: *White Spots on Teeth:* ☐ *Yes* ☐ *No* ☐ Daily Brushing *(Twice Daily by Parent)* ☐ Fluoride Supplement
☐ **Fluoride Varnish by PCP** *(Once Every 6 Months)* First Dental Appointment ☐ *Completed* ☐ *Scheduled* Dental Home Provider:_____

NUTRITIONAL SCREENING: ☐ Feeds Self ☐ Breastfeeding ☐ Whole Milk ☐ Nutritionally Balanced Diet ☐ Junk Food ☐ Soda/Juice
☐ Solids ☐ Activity ☐ Supplements _____ ☐ **Overweight** ☐ **Underweight** ☐ *Observation* ☐ *Referral*

DEVELOPMENTAL SURVEILLANCE: ☐ Says 3-6 words ☐ Says No ☐ Wide Range of Emotions ☐ Repeats Words from Conversation
☐ Uses Utensils ☐ Understands Simple Commands ☐ Climbs Stairs ☐ Walking ☐ Puts Objects In/Out of Container ☐ Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency /911 ☐ Gun Safety ☐ Drowning Prevention ☐ Choking Prevention
☐ Car/Car Seat Safety *(Rear-Facing)* ☐ Safety at Home/Child-Proofing ☐ Sun Safety ☐ Helmet Use ☐ Growing Independence
☐ Defiant Behavior/Offer Child Choices ☐ Gentle Limit Setting/Redirection/Safety ☐ Reading/Parent Asks Child "What's that?
☐ Follow Child's Lead in Play ☐ Offer Opportunity to Scribble/Explore ☐ Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child
☐ Appropriate Bonding/Responsive to Needs ☐ Self-Calming ☐ Frustration/Hitting/Biting/Impulse Control ☐ Communication/Language
☐ Social Interaction/Eye Contact/Comforts Others ☐ Begins to Have Definite Preferences ☐ Other: _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			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/Not already Done at 12 Months)* ☐ Finger Stick (*Result:* ___) ☐ Venous
☐ 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**