

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Admitted to NICU: (Birth)	Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss:		Temp: <input type="text"/>
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		Pulse: <input type="text"/>
Allergies:			Weight:		Length:
			lb	oz	%
			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?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

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: Uses a cup Walks Says 10-20 Words Says "No" Name One Picture/2 Colors
 Follows Simple Rules/Bring Me the Book Knows Animal Sounds 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 Never Leave Toddler Alone
 Sibling Interaction Discipline/Limits Growing Independence Encourage Expression of Wide Range of Emotions
 Read to Child 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
 Demonstrates Increasing Independence Defiant Behavior/Offer Child Choices 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