18-21 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/CONCERNS: *(Current Concerns/ Follow-Up on Previously Identified Concerns)*

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: ☐ Abstract Thinking ☐ School Attendance ☐ Sexuality/Orientation
☐ Physical Growth and Development ☐ Other ________________________

ANTICIPATORY GUIDANCE PROVIDED: ☐ Emergency/911 ☐ Violence Prevention/Gun Safety ☐ Drowning/Sun Safety
☐ Car/Seat Belt/Driving Safety ☐ Safety at Home ☐ Sports/Injury Prevention ☐ Peer Refusal Skills ☐ Age Appropriate Limits
☐ Self-Control ☐ Sex Education/STI/Resources ☐ Availability of Family Planning Services ☐ Social Interaction/Dating
☐ Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants ☐ Risks of Tattoos/ Piercing ☐ Education Goals/Activities ☐ Job/Career Planning
☐ Parenting Advice *(As Appropriate)* ☐ Other ____________________________

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Philosophical/Idealistic ☐ Comfortable Body Image
☐ Self-Confident ☐ Building Intimate/ Complex Relationships ☐ Depression/Anxiety/Sleep Issues ☐ Mood Changes ☐ 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 ☐ Refused ☐ Delayed ☐ Deferred *Reason*: ___________________________
☐ Shot Record Updated/Entered in ASIIS ☐ Importance of Immunizations Discussed ☐ 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**

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