

30 MONTHS OLD - AHCCCS EPSDT CLINICAL SAMPLE TEMPLATE

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	Temp:	Pulse: Resp:
Allergies:		Weight:	Height:		BMI:
		lb / kg %	cm %	kg/m ²	%
Vision Screening:	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No	Device <input type="checkbox"/> Chart	Right: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Both: <input type="checkbox"/> Pass <input type="checkbox"/> Refer
Hearing	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age-Appropriate Speech:	Yes No

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL/HEALTH CARE DECISION MAKER CONCERNS: How are you feeling about your child? 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)

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing with help (Twice Daily by Parent) Fluoride Supplement
 Fluoride Varnish by PCP (Every 3 months)

NUTRITIONAL SCREENING: Nutritionally Balanced Diet Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-30mo.html> Uses Imaginary Characters/Plays Pretend Puts 3-5 Words Together Points to 6 body parts Other people can understand what your child is saying half the time Names Self & Others Begins to Play Interactive Games Jumps Up and Down in Place Puts on clothes with help Knows correct animal sound (i.e. cat meows) Washes and dries hands without help Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Sports/Helmet Use TV Screen Time
 Supervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting Preschool
 Provide Opportunities for Fantasy Play/Problem Solving Allow Child to Play Independently/Be Available if Child Seeks You Out
 Encourage Literacy/Daily Reading Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child Manage Anger
 "Monster" Fear Frustration/Hitting/Biting/Impulse Control Separates Easily from Parent Shows Interest in Other Children
 Objects to Major Change in Routine Kind to Animals 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 (Child At Risk/Not Already Done at 12/24 Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza Had Chicken Pox 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 ACC DDD Dental Head Start OT PT Speech WIC Specialist Developmental
 Behavioral Other _____

PROVIDER'S SIGNATURE: _____ NPI: _____ Date: _____