FOUR YEARS 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 Pressure:	Temp:	Pulse:	Resp:

Allergies:	Weight:		Height:		BMI:	
	lb / kg	%	cm	%	kg/m²	%

Vision Screening:	Corrected: ☐Yes ☐No	Device ☐ Chart ☐	Right: ☐ Pass ☐ Refer	Left: ☐ Pass ☐ Refer	Both: ☐ Pass ☐ Refer
Hearing Screening:	Right: ☐ Pass ☐ Refer	Left: ☐ Pass ☐ Refer	☐ 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 child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk ☐ Yes ☐ No (Appropriate Action to Follow)

ORAL HEALTH: White Spots on Teeth: ☐ Yes ☐ No ☐ Daily Brushing (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-4yr.html ☐Sings a Song ☐Draws a Person with 3 Parts ☐Names Self & Others ☐Names 4 Colors/3 Shapes ☐Counts 1-7 Objects Out Loud (Not Always in Order) ☐Shows Interest in Other Children ☐Dresses Self ☐Brushes Own Teeth

ANTICIPATORY GUIDANCE PROVIDED: ☐Emergency/911 ☐Gun Safety ☐Drowning Prevention ☐Choking Prevention ☐Sun Safety ☐Car /Car Seat Safety (Forward Facing) ☐Safety at Home/Child-Proofing ☐Sports/Helmet Use ☐Good and Bad Touches ☐Positive Discipline / Redirect ☐Reading/Preschool ☐School Readiness ☐Allow Child to Play Independently/be Available if Child Seeks You Out ☐Other

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐Family Adjustment/Parent Responds Positively to Child ☐ Self-Calming ☐Separates Easily from Parent ☐Kind to Animals ☐Objects to Major Change in Routine ☐ Has Words for Feelings ☐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 ☐ CRS ☐ DDD ☐ Dental ☐ Head Start ☐ OT ☐ PT ☐ Speech ☐ WIC Specialist: ☐ Developmental ☐ Behavioral ☐ Other_____
PROVIDER'S SIGNATURE:	_____ NPI: _____ Date: _____

Effective Dates: 03/01/19, 05/07/19, 02/01/22, 10/01/22, 11/28/23, 10/01/24

Approval Dates: 07/01/01, 06/01/03, 11/01/03, 01/01/04, 11/01/07, 10/01/09, 04/01/14, 10/18/18, 02/21/19, 10/07/21, 07/14/22, 08/17/23, 08/26/24