SEVEN TO EIGHT 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/m^2	%

Vision Chart Exam:	Right	Left	Both	Corrected ☐ Yes ☐ No	☐ Unable to Perform

Audiometry: ☐ Within Normal Limits ☐ Abnormal	Age Appropriate Speech: ☐ Yes ☐ No

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

PARENTAL/HEALTH CARE DECISION MAKER CONCERNS: How do you feel about your child? Do you feel safe in your home?

ORAL HEALTH: White Spots on Teeth: ☐ Yes ☐ No ☐ Daily Brushing 2x Daily/Flossing ☐ Dental Sealants ☐ Fluoride Supplement
Last Dental Appointment:_____ ☐ Future Dental Appointment Scheduled Dental Home: Provider Name_____

NUTRITIONAL SCREENING: ☐ Nutritionally Balanced Diet/5 Servings Fruits & Veggies ☐ Low-Fat Milk ☐ Junk Food ☐ Soda/Juice
☐Supplements_____ ☐ Activity/Family Exercise (1 hr/day) ☐ Overweight ☐ Underweight ☐ Observation ☐Referral

DEVELOPMENTAL SURVEILLANCE: ☐ School Attendance ☐ Reading at Grade Level ☐ School Performance ☐ IEP/504 Plan
☐Discuss Body Changes ☐Has Friends ☐ Does Chores When Asked ☐Other _____

ANTICIPATORY GUIDANCE PROVIDED: ☐Emergency/911 ☐Gun Safety ☐Drowning Prevention ☐Choking Prevention
☐ Car /Car Seat Safety (Booster Seat for under 4'9" height) ☐Safety at Home ☐Sun Safety ☐ Sport/Bike Helmet Use
☐Bullying/Fighting

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): ☐ Family Adjustment/Parent Responds Positively to Child
☐Frustration /Impulse Control ☐ Communication/Language ☐ Comfortable Body Image ☐ Encourage Independence
☐Praise Strengths ☐ 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: ☐TB Skin Test (If at Risk) ☐ Hgb/Hct ☐Other _____

IMMUNIZATIONS ORDERED: ☐HepA ☐ HepB ☐ MMR ☐ Varicella ☐ Td ☐ IPV ☐ Influenza ☐ Had Chicken Pox ☐ Other _____
☐Given at Today's Visit ☐ Parent Refused ☐Delayed ☐Deferred Reason: _____

REFERRALS: ☐ALTCS ☐ Audiology ☐ CRS ☐DDD ☐Dental ☐ OT ☐ PT
☐Speech Specialist: ☐ Developmental ☐ Behavioral ☐ Other _____

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

Effective Dates: 03/01/19, 05/07/19, 03/01/19, 02/01/22, 10/01/22, 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, 04/16/20, 10/07/21, 7/14/22,08/17/23, 08/26/24