

FOUR 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	

Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:		Temp:	Pulse:	Resp:
		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Allergies:	Birth Weight:	Weight:		Length:		Head Circumference:
	lb oz	lb oz	%	cm	%	cm %

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

PARENTAL/HEALTH CARE DECISION MAKER CONCERNS: How are you feeling about baby? Do you feel safe in your home?

ORAL HEALTH: Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: Breastfeeding Frequency/Duration: _____ Supplements: _____ Vit D
 Formula Type: _____ Amount/Duration: _____ Adequate Weight Gain Yes No Receiving WIC Services
 Cereal Type: _____ Plan to Introduce Solids _____ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-4mo.html>

Babbles and Coos Laughs Begins to Roll Front to Back Pushes Up with Arms
 Controls Head Well Reaches for Objects Interest in Mirror Images Pushes Down with Legs When Feet on Surface

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention Safe Bathing/Water Temperature
 Passive Smoke Safety at Home/Child-Proofing Sun Safety Bottle Propping Support Systems/Resources
 Infant Crying/Appropriate Interventions Discuss Child Temperament Establish Daily Routines/Infant Regulation
 Establish Nighttime Sleep Routine/Sleep Through Night (Greater 5 hours) Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH AND (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Baby

Infant Hands to Mouth/Self-Calming Smiles When Hears Parents' Voices Appropriate Bonding/Responsive to Needs
 Easily Distracted/Excited by Discovery of Outside World Postpartum Depression Screen 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: Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Rotavirus 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 _____

PROVIDER'S

SIGNATURE: _____ **NPI:** _____ **Date:** _____