

TWO 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:	Temp:	Pulse:	Resp:	
Allergies:	Birth Weight:	Weight:		Length:	Head Circumference:
	lb oz	lb oz	%	cm	%

Risk Indicators of Hearing Loss: Yes No

Hospital Newborn Hearing Screen: ABR OAE: Rt. Ear Pass Refer Lt. Ear Pass Refer Unknown

Second Newborn Hearing Screen (If 2nd Needed/Completed): ABR OAE: Rt. Ear Pass Refer Lt. Ear Pass Refer Unknown

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

DEVELOPMENTAL SURVEILLANCE: <https://www.cdc.gov/ncbddd/actearly/milestones/milestones-2mo.html> Some Head Control
 Tummy Time/Lifts Head, Neck with Forearm Support Social Smile
 Coos Begins Imitation of Movement and Facial Expressions Makes Eye Contact Fixes/Follows with Eyes to Midline

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 Pacifier Use Bottle Propping Infant Bonding Support Systems/Resources
 Infant Crying/Appropriate Interventions Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Infant Hands to Mouth/Self-Calming Enjoys Interacting with Others
 Postpartum Depression Screen Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)	WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs	
Eyes/Vision/Red Reflex			Abdomen	
Ear			Genitourinary	
Mouth/Throat/Teeth			Extremities	
Nose/Head/Neck			Spine	
Heart			Neurological	

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: 2nd Arizona Newborn Screening Bloodspot Test (If Needed) Other _____
 Results of 2nd AZ Newborn Screening Received (If No, What Follow Up Taken: _____)

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:** _____