THREE TO FIVE DAYS 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) ☐ Yes ☐ No

Current Medications/Vitamins/Herbal Supplements:

Temp:	Pulse:	Resp:

Allergies:

Birth Weight:	Weight:		Length:		Head Circumference:	
lb oz	lb oz	%	cm	%	cm	%

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: ☐ Rooting Reflex ☐ Startle ☐ Suck & Swallow ☐ Other ____________________

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 ☐ 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 ☐ 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 (5 – 10 Days of Age or First PCP Visit) ☐ Other ______________

IMMUNIZATIONS ORDERED: **Date 1st Hep B administered:**___________ ☐ Hep B (Not Previously Administered) ☐ 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______________ ☐ 2nd Newborn Hearing Screen (If Needed)

PROVIDER'S SIGNATURE: ______________________ NPI:________________ Date:______________________