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) ○ Yes ○ No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:

Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: 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 ☐ 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
_____ NPI:_____ Date:_____

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