Health Check 21 Months
For growth / development monitoring

Patient's actual age:

Indigenous status: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin
☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal or Torres Strait Islander origin
☐ Not stated / unknown

Parent / carer's name: ___________________________ Relationship: ___________________________
Consent for health check: ___________________________ Date: ____________

Has the carer / parent been advised of the process and benefits of health check? ☐ Yes ☐ No

Medical history
Current problems / concerns:

Examination (*MO's note: examination requirements on following pages):

Medications:

Immunisations status: ☐ Current ☐ Not current

Immunisations due:

Measurements
Print name: ___________________________ Signature: ___________________________ Date: ____________

Weight
kg (___________ %ile)

Length
cm (___________ %ile)

Haemoglobin

Nutrition
Print name: ___________________________ Signature: ___________________________ Date: ____________

Breast feeding only ☐ Yes ☐ No
Formula feeding only ☐ Yes ☐ No
Breast feeding and formula only ☐ Yes ☐ No

Solids
Uses a cup ☐ Yes ☐ No
Uses a bottle ☐ Yes ☐ No

Healthy food
Cereal with iron ☐ Yes ☐ No
Vegetables ☐ Yes ☐ No
Meat ☐ Yes ☐ No
Fruit ☐ Yes ☐ No
Fish ☐ Yes ☐ No
Water ☐ Yes ☐ No

Unhealthy food
Coke / soft drink ☐ Yes ☐ No
Junk food ☐ Yes ☐ No
Juice ☐ Yes ☐ No
Tea ☐ Yes ☐ No
Cordial ☐ Yes ☐ No
Cow's milk ☐ Yes ☐ No

If your child was hungry are you always able to provide food? ☐ Yes ☐ No

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## Environment

<table>
<thead>
<tr>
<th>Print name:</th>
<th>Signature:</th>
<th>Date:</th>
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</thead>
</table>

### Is the child exposed to cigarette smoke?
- [ ] Yes
- [ ] No

### How many people live in the house?

### Where does the baby sleep?

### Is the child placed on their back to sleep?
- [ ] Yes
- [ ] No

## Topics for discussion / education

- [ ] Cross infection
- [ ] Injury prevention
- [ ] Breast feeding and maternal nutrition
- [ ] Sudden infant death syndrome

## Action plan for good health

<table>
<thead>
<tr>
<th>Risks identified</th>
<th>Referrals / actions</th>
<th>Initial</th>
<th>Date</th>
</tr>
</thead>
</table>

## Actions to be taken by patient / carer

## All risks, outcomes and results discussed and explained to carer / parent by MO?
- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Medical Officer signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

## Written feedback report provided to carer / parent?
- [ ] Yes
- [ ] No

<table>
<thead>
<tr>
<th>Carer / parent signature:</th>
<th>Date:</th>
</tr>
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</table>

## Care plans / follow up assigned on PHCIS?
- [ ] Yes
- [ ] No

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**Health Check**

**21 Months**

**For growth / development monitoring**

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**URN:**

**Family name:**

**Given name(s):**

**Address:**

**Date of birth:**

**Sex:**  
- [ ] M
- [ ] F
- [ ] I

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