Queensland Government

Health Check 4 months

Medicare Item No. 228, 715, 10987

Facility: _____

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Patient's actual age:

Indigenous status: ☐ Aboriginal only ☐ Torres Strait Islander only ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not stated/unknown

Parent / carer's name:	Relationship:	Signature (health check consent):	Date:

Have all the benefits, risks, outcomes and results of this health assessment been discussed and explained to the parent/carer by the clinician? ☐ Yes ○ No

Legend: ○ Indicates a health risk requiring brief intervention, follow up or action. For support see the Chronic Conditions Manual

Family History

Medical History

Current problems/concerns

Allergies

Immunisation status

Has the child had all age related eligible vaccines? ☐ Yes ○ No

Vaccines due _____ Initial Date

DO NOT WRITE IN THIS BINDING MARGIN

HEALTH CHECK 4 MONTHS

Family name:	Given name(s):	URN:

Body measurements

Weight	____ kg	(..... %le) ☐ Healthy ○ Underweight ○ Overweight
Length	____ cm	(..... %le) ☐ Healthy ○ Other
Head circumference	____ cm	(..... %le) ☐ Normal ○ Other
Anterior fontanelle	☐ Normal	○ Other _____
Posterior fontanelle	☐ Normal	○ Other _____

Initial Date

Clinical measurements

Breathing	☐ Normal	○ Other _____	Date
Heart sounds	☐ Normal	○ Other _____	
Femoral pulses	☐ Normal	○ Other _____	Initial

General appearance

Head, neck and face	☐ Healthy	○ Other _____				
Limbs and joints	Hips abduct equally:	☐ Yes	○ No			
	Buttock creases equal:	☐ Yes	○ No			
Genitalia	Appearance:	☐ Normal	○ Other			
	Left teste:	☐ Descended	○ Undescended	○ Not found	☐ N/A	Date
	Right teste:	☐ Descended	○ Undescended	○ Not found	☐ N/A	Initial

Skin

Has the baby had any skin infections?	☐ No	○ Yes	Date
Inspect skin. Any concerns? Describe	☐ Normal	○ Other _____	Initial

Reflexes

Plantar	☐ Present	○ Absent	Blink	☐ Present	○ Absent

Initial Date

Developmental milestones

Any parental concerns according to PEDS assessment? (See child's PHR booklet)	○ Yes	☐ No
Difference in strength, movement and tone between right and left sides of body?	○ Yes	☐ No
Significant loss of skills?	○ Yes	☐ No
Poor interaction with adults or other children?	○ Yes	☐ No
Lack of response to sound or visual stimuli?	○ Yes	☐ No
Loose and floppy movements (low tone) or stiff and tense (high tone)?	○ Yes	☐ No
Not achieving indicated developmental milestones?	○ Yes	☐ No
Lack of or limited eye contact?	○ Yes	☐ No

If "Yes" to any of the above, perform ASQ or ASQ-TRAK and refer

Initial Date

Ears and hearing

Does the parent think their baby can hear them?	☐ Yes	○ No
Does the baby look or turn towards sounds or voices?	☐ Yes	○ No
Is the parent happy with their baby's hearing?	☐ Yes	○ No
Has the baby been free of ear infections or discharge?	☐ Yes	○ No

If 'No' to any above OR of Aboriginal and Torres Strait Islander descent OR from a rural and remote location perform otoscopy

Date

Otoscopy	Right ear: ☐ Healthy	○ Refer _____	Initial
	Left ear: ☐ Healthy	○ Refer _____	

Continence/ elimination

How many wet nappies does the baby have per day?	☐ Normal (5+)	○ Other
Is the parent worried about their baby's bowel movements?	☐ No	○ Yes

Initial Date

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Eyes and vision

Eye appearance	☐ Normal	○ Other	
Red eye reflex	☐ Present	○ Absent	
Fixates and follows an object	☐ Present	○ Absent	
Corneal light reflex	☐ Present	○ Absent	Initial Date

Nutrition

Breast or formula feeding?	☐ Yes	○ No	
Any other food or drink?	☐ No	○ Yes	
Does the child always have access to food?	☐ Yes	○ No	Initial Date

Physical activity

Does the baby do floor based play daily e.g. tummy time?	☐ Yes	○ No	Initial Date

Social-emotional wellbeing

Does the parent/carer have concerns about:

Coping?	☐ No	○ Yes	
Relationships (with family or friends)?	☐ No	○ Yes	
Support?	☐ No	○ Yes	
Violence?	☐ No	○ Yes	
Child's behaviour?	☐ No	○ Yes	
Observe: Is interaction between parent and baby positive?	☐ Yes	○ No	
If any concerns raised above, perform SDQ	Score: _____		Initial Date

Environment

Where does the baby sleep?	☐ Cot	○ Other	
Is the baby placed on their back to sleep?	☐ Yes	○ No	
Is the baby exposed to cigarette smoke?	☐ No	○ Yes	
How many people live in the house?	_____		
Any observed safety concerns?	☐ No	○ Yes	Initial Date

Anticipatory guidance

- » Talking and reading to your baby
- » Being close to your baby, cuddling, smiling and listening (bonding)
- » Injury prevention and reducing home hazards (e.g. car capsules)
- » Sun protection
- » Strategies for settling
- » Avoiding screen time
- » Support groups
- » Partner support and coping with baby
- » Contraception
- » Breast care, breastfeeding (attachment)
- » Normal developmental milestones
- » Handwashing
- » Sudden infant death syndrome

Initial Date

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Note any required actions and transfer to Care Management Plan

Medicare

Medicare item being claimed? ☐ Yes ○ No

All benefits, risks, outcomes and results of this health assessment discussed and explained to carer/parent by clinician? ☐ Yes ○ No (can not claim Medicare)

Written or photocopied feedback of action plan provided to parent? ☐ Yes ○ No (can not claim Medicare)

Medicare claim form signed by parent? ☐ Yes ○ No (can not claim Medicare)

Doctor name	Signature	Date

Signature log

Signature	Name	Date	Initial

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