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Health Check 6 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

DO NOT WRITE IN THIS BINDING MARGIN

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

HEALTH CHECK 6 MONTHS

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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
Heart sounds	☐ Normal	○ Other
Femoral pulses	☐ Normal	○ Other
Haemoglobin	______ g/L	

Initial Date

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
	Right teste:	☐ Descended	○ Undescended	○ Not found	☐ N/A

Date Initial

Skin

Has the infant had any skin infections?	☐ No	○ Yes
Inspect skin. Any concerns? Describe	☐ Normal	○ Other ______

Initial Date

Reflexes

Plantar	☐ Present	○ Absent

Initial Date

Developmental milestones

Smiles or squeals in response to people	○ No	☐ Yes
Babbling i.e. oohh, aahh	○ No	☐ Yes
Recognises their name when called	○ No	☐ Yes
Reaching for and holding toys (palmer grasp)	○ No	☐ Yes
Explores objects with hands, eyes and mouth	○ No	☐ Yes
Brings hands together at midline	○ No	☐ Yes
Supports head when held in sitting position	○ No	☐ Yes
Holding head and shoulders up when on tummy	○ No	☐ Yes

If 'No' to any above, perform an ASQ or ASQ-TRAK and refer

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 above, perform an ASQ or ASQ-TRAK and refer

Date Initial

Eyes\vision

Red eye reflex	☐ Present	○ Absent
Fixates and follows an object	☐ Present	○ Absent
Corneal light reflex equal	☐ Present	○ Absent

Initial Date

Physical activity

Does the infant do floor based play daily e.g. tummy time, rolling, crawling, cruising etc.?	☐ Yes	○ No

Initial Date

Oral health

Does the infant have any teeth?	☐ Yes	○ No
Examination of gums and teeth adequate?	☐ Yes	○ No
Does the parent clean the infant's teeth?	☐ Yes	○ No

Initial Date

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Queensland Government

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Ears and hearing

Does the parent think their infant can hear them?	☐ Yes	○ No
Does the infant turn towards sounds or voices?	☐ Yes	○ No
Is the parent happy with their infant's hearing?	☐ Yes	○ No
Has the infant 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 and tympanometry

Otoscopy (describe)	Right ear:	☐ Healthy	○ Refer ______	
	Left ear:	☐ Healthy	○ Refer ______	
Tympanometry	Right ear:	☐ Type A	○ Type B	○ Type C
	Left ear:	☐ Type A	○ Type B	○ Type C

Initial Date

Continence elimination

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

Initial Date

Nutrition

Breast or formula feeding?	☐ Yes	○ No
Eating solids?	☐ Yes	○ No
Uses a cup or bottle?	☐ Yes	○ No
Healthy foods and drinks?	☐ Yes	○ No
Nutritionally poor foods and drinks?	☐ No	○ Yes
Does the infant always have access to food?	☐ 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/vape 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 infant
» Being close to your infant, cuddling, smiling, eye contact and listening (bonding)
» Injury prevention and reducing home hazards (e.g. car capsules)
» Sun protection
» Age appropriate healthy eating, fussy eating and strategies
» Strategies for settling
» Avoiding screen time
» Support groups
» Partner support and coping with infant
» Contraception
» Breast care, breastfeeding (attachment)
» Normal developmental milestones
» Handwashing
» Sudden infant death syndrome

Initial Date

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Family name:	Given name(s):	URN:

Note any required actions and transfer to Care Management Plan

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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