Queensland Government

Health Check 9 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 infant had all age related eligible vaccines? ☐ Yes ○ No

Vaccines due:

Initial Date

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HEALTH CHECK 9 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 Initial Date

Clinical measurements

Breathing	☐ Normal	○ Other
Heart sounds	☐ 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	Date
	Right teste:	☐ Descended	○ Undescended	○ Not found	☐ N/A	Initial

Skin

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

Developmental milestones

Shares enjoyment with others using eye contact or facial expression	○ No	☐ Yes
Gesturing e.g. pointing, waving, showing	○ No	☐ Yes
Using 2 part babble e.g. mama, dada, gaga	○ No	☐ Yes
Holds objects	○ No	☐ Yes
Gives objects when requested	○ No	☐ Yes
Moves toys from one hand to another	○ No	☐ Yes
Rolling	○ No	☐ Yes
Sits without support	○ No	☐ Yes
Moves e.g. creeping or crawling motion	○ No	☐ Yes
Bears weight on legs well when held upright	○ 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 Initial Date

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

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Eyes\ vision

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

Nutrition

			Initial	Date
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		

Oral health

			Initial	Date
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		

Physical activity

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

Social-emotional wellbeing

			Initial	Date
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: _____			

Environment

			Initial	Date
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		

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
- » Strategies for settling
- » Age appropriate healthy eating, fussy eating and strategies
- » 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

Family name:	Given name(s):	URN:

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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