



# Health Check 18 months Medicare Item No. 228, 715, 10987

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F

Facility: \_\_\_\_\_

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

Family name:	Given name(s):	URN:
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Body measurements	Weight	<input type="text"/>	kg	( ..... %ile)	<input type="checkbox"/> Healthy	<input type="radio"/> Underweight	<input type="radio"/> Overweight	
	Length	<input type="text"/>	cm	( ..... %ile)	<input type="checkbox"/> Healthy	<input type="radio"/> Other		
	Head circumference	<input type="text"/>	cm	( ..... %ile)	<input type="checkbox"/> Normal	<input type="radio"/> Other		
	Anterior fontanelle	<input type="checkbox"/> Normal		<input type="radio"/> Other				<input type="button" value="Initial"/> <input type="button" value="Date"/>

Clinical measurements							
Breathing	<input type="checkbox"/> Normal		<input type="radio"/> Other				
Heart sounds	<input type="checkbox"/> Normal		<input type="radio"/> Other				
Haemoglobin	<input type="text"/>		g/L				<input type="button" value="Initial"/> <input type="button" value="Date"/>

General appearance	Head, neck and face	<input type="checkbox"/> Healthy		<input type="radio"/> Other _____		
	Limbs and joints	Hips abduct equally:	<input type="checkbox"/> Yes	<input type="radio"/> No		
		Buttock creases equal:	<input type="checkbox"/> Yes	<input type="radio"/> No		
	Genitalia	Appearance:	<input type="checkbox"/> Normal	<input type="radio"/> Other _____		
Left teste:		<input type="checkbox"/> Descended	<input type="radio"/> Undescended	<input type="radio"/> Not found	<input type="checkbox"/> N/A <input type="button" value="Date"/>	
Right teste:		<input type="checkbox"/> Descended	<input type="radio"/> Undescended	<input type="radio"/> Not found	<input type="checkbox"/> N/A <input type="button" value="Initial"/>	

Skin	Has the child had any skin infections?	<input type="checkbox"/> No	<input type="radio"/> Yes		
	Inspect skin. Any concerns? Describe	<input type="checkbox"/> Normal	<input type="radio"/> Other		<input type="button" value="Initial"/> <input type="button" value="Date"/>

Developmental milestones	Shows interest in playing and interacting with others?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Clear words spoken?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Understands short requests e.g. where is the ball?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Scribbles with a crayon?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Attempts to stack blocks after demonstration?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Attempts to walk without support?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	Stands alone?	<input type="radio"/> No	<input type="checkbox"/> Yes	
	<b>If 'No' to any above, perform an ASQ or ASQ-TRAK and refer</b>			
	Any parental concerns according to PEDS assessment? (See child's PHR booklet)	<input type="radio"/> Yes	<input type="checkbox"/> No	
	Difference in strength, movement and tone between right and left sides of body?	<input type="radio"/> Yes	<input type="checkbox"/> No	
Significant loss of skills?	<input type="radio"/> Yes	<input type="checkbox"/> No		
Poor interaction with adults or other children?	<input type="radio"/> Yes	<input type="checkbox"/> No		
Lack of response to sound or visual stimuli?	<input type="radio"/> Yes	<input type="checkbox"/> No		
Loose and floppy movements (low tone) or stiff and tense (high tone)?	<input type="radio"/> Yes	<input type="checkbox"/> No		
Not achieving indicated developmental milestones?	<input type="radio"/> Yes	<input type="checkbox"/> No		
Lack of or limited eye contact?	<input type="radio"/> Yes	<input type="checkbox"/> No		
<b>If 'Yes' to any above, perform an ASQ or ASQ-TRAK and refer</b>				
<input type="button" value="Initial"/> <input type="button" value="Date"/>				

Ears and hearing	Does the parent think their child can hear them?	<input type="checkbox"/> Yes	<input type="radio"/> No
	Does the child turn towards sounds or voices?	<input type="checkbox"/> Yes	<input type="radio"/> No
	Is the parent happy with their child's hearing?	<input type="checkbox"/> Yes	<input type="radio"/> No
	Has the child been free of ear infections or discharge?	<input type="checkbox"/> Yes	<input type="radio"/> No
	Is the parent happy with their child's speech or language?	<input type="checkbox"/> Yes	<input type="radio"/> No
	<b>If 'No' to any above OR of Aboriginal and Torres Strait Islander descent OR from a rural and remote location perform otoscopy and tympanometry</b>		
Otoscopy (describe)	Right ear:	<input type="checkbox"/> Healthy	<input type="radio"/> Other _____
	Left ear:	<input type="checkbox"/> Healthy	<input type="radio"/> Other _____
Tympanometry	Right ear:	<input type="checkbox"/> Type A	<input type="radio"/> Type B <input type="radio"/> Type C
	Left ear:	<input type="checkbox"/> Type A	<input type="radio"/> Type B <input type="radio"/> Type C
<input type="button" value="Initial"/> <input type="button" value="Date"/>			

Physical activity			
Is the child physically active for > 3 hrs/day?	<input type="checkbox"/> Yes	<input type="radio"/> No	
<input type="button" value="Initial"/> <input type="button" value="Date"/>			

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**Health Check  
18 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

**Eyes  
vision**

Fixates and follows an object  
Red eye reflex  
Corneal light reflex equal

Present  Absent  
 Present  Absent  
 Present  Absent

Initial Date

**Nutrition**

Breast or formula feeding?  
Eating solids?  
Uses a cup or bottle?  
Healthy foods and drinks?  
Nutritionally poor foods and drinks?  
Does the child always have access to food?

Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 No  Yes  
 Yes  No

Initial Date

**Oral  
health**

Does the child have any teeth?  
Examine the gums and teeth. Adequate?  
Does the parent clean the child's teeth?

Yes  No  
 Yes  No  
 Yes  No

Initial Date

**Social-emotional  
wellbeing**

**Does the parent/carer have concerns about:**

- » Coping?
- » Relationships (with family or friends)?
- » Support?
- » Violence?
- » Child's behaviour?

No  Yes  
 No  Yes  
 No  Yes  
 No  Yes  
 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 child sleep?  
Is the child placed on their back to sleep?  
Is the child exposed to cigarette/vape smoke?  
How many people live in the house?  
Any observed safety concerns?

Cot  Other  
 Yes  No  
 No  Yes  
\_\_\_\_\_  
 No  Yes

Initial Date

**Anticipatory guidance**

- » Talking and reading to your child
- » Being close to your child, cuddling, smiling and listening (bonding)
- » Injury prevention and reducing home hazards (e.g. car capsules)
- » Sun protection
- » Strategies for settling
- » Avoiding screen time
- » Child tooth decay
- » Age appropriate healthy eating, fussy eating and strategies
- » Toilet training
- » Day Care
- » Normal developmental milestones
- » Child behaviour and parenting strategies
- » Sibling rivalry
- » Hand washing

Initial Date

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HEALTH CHECK 18 MONTHS

Family name:	Given name(s):	URN:
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Note any required actions and transfer to Care Management Plan	

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Medicare	Medicare item being claimed? <span style="float: right;"><input type="checkbox"/> Yes <input type="radio"/> No</span>					
	All benefits, risks, outcomes and results of this health assessment discussed and explained to carer/parent by clinician? <span style="float: right;"><input type="checkbox"/> Yes <input type="radio"/> No (can not claim Medicare)</span>					
	Written or photocopied feedback of action plan provided to parent? <span style="float: right;"><input type="checkbox"/> Yes <input type="radio"/> No (can not claim Medicare)</span>					
	Medicare claim form signed by parent? <span style="float: right;"><input type="checkbox"/> Yes <input type="radio"/> No (can not claim Medicare)</span>					
	<table border="0" style="width: 100%;"> <tr> <td style="width: 40%;">Doctor name</td> <td style="width: 30%;">Signature</td> <td style="width: 30%;">Date</td> </tr> <tr> <td><input style="width: 95%;" type="text"/></td> <td><input style="width: 95%;" type="text"/></td> <td><input style="width: 95%;" type="text"/></td> </tr> </table>	Doctor name	Signature	Date	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Doctor name	Signature	Date				
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>				

Signature log	Signature	Name	Date	Initial