Queensland Government

# Health Check
# 18 months
## Medicare Item No. 715

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 but not Torres Strait Islander
☐ Torres Strait Islander but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Neither Aboriginal or Torres Strait Islander
☐ Not stated / unknown

| Parent / carer's name: | Relationship: | Signature (consent for health check): | 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 that requires brief intervention, follow up or action. To clarify any health check items refer to the current edition of 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 18 MONTHS

v3.00 - 10/2020
Mat. No.:
SW990

| Family name: | Given name(s): | URN: |
|---|---|---|

## Body measurements

| | | |
|---|---|---|
| Weight | ____ kg | ( ..... %le) ☐ Healthy ◯ Underweight ◯ Overweight |
| Length | ____ cm | ( ..... %le) ☐ Normal ◯ Other |
| Head circumference | ____ cm | ( ..... %le) ☐ Normal ◯ Other |
| Anterior fontanelle | ☐ Normal ◯ Other | Initial Date |

## Clinical measurements

| | | |
|---|---|---|
| Breathing | ☐ Normal ◯ Noisy ◯ Cough ◯ Wheeze ◯ Breathless | |
| Heart sounds | ☐ Normal ◯ Other | |
| Haemoglobin | ____ g/L | Initial Date |

## General appearance

| | | |
|---|---|---|
| Head and face | ☐ Healthy ◯ Other _____ | |
| Limbs and joints | ☐ Normal ◯ Other _____ | Initial Date |

## Skin

| | | |
|---|---|---|
| Has the baby had any skin infections? | ☐ No ◯ Yes | |
| Observe | ☐ Healthy ◯ Other _____ | Initial Date |

## Developmental milestones

**If child has not achieved the developmental milestone by the given age, perform a PEDS and/or ASQ and refer**

| | |
|---|---|
| Shows interest in playing and interacting with others | ☐ Yes ◯ No |
| Words are clear | ☐ Yes ◯ No |
| Understands short requests e.g. where is the ball? | ☐ Yes ◯ No |
| Scribbles with a crayon | ☐ Yes ◯ No |
| Attempts to stack blocks after demonstration | ☐ Yes ◯ No |
| Attempts to walk without support | ☐ Yes ◯ No |
| Stands alone | ☐ Yes ◯ No |

**If any of the following exists, perform a PEDS and/or ASQ and refer**

| | |
|---|---|
| Any parental concerns | ◯ 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 |

Date

Initial

## Ears and hearing

| | |
|---|---|
| Does the parent think their child can hear them? | ☐ Yes ◯ No |
| Does the child turn towards sounds or voices? | ☐ Yes ◯ No |
| Is the parent happy with their child's hearing? | ☐ Yes ◯ No |
| Has the child been free of ear infections or discharge? | ☐ Yes ◯ No |
| Is the parent concerned about their child's speech and language? | ◯ 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 | Right ear: | ☐ Healthy ◯ Other _____ |
| | Left ear: | ☐ Healthy ◯ Other _____ |
| Tympanometry | Right ear: | ☐ Type A ◯ Type B ◯ Type C |
| | Left ear: | ☐ Type A ◯ Type B ◯ Type C |

Initial Date

## Physical activity

| | |
|---|---|
| Is the child physically active for at least 3 hours per day? | ☐ Yes ◯ No |

Initial Date

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(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

## Eyes and vision

| | | | |
|---|---|---|---|
| Child fixates and follows an object | Near: ☐ Yes | ◯ No | |
| | Far: ☐ Yes | ◯ No | |
| Red eye reflex | ☐ Present | ◯ Absent | Date |
| Corneal light reflex equal | ☐ Yes | ◯ Absent | Initial |

## Nutrition

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Eating solids | ☐ Yes | ◯ No | | | | | | |
| Uses a cup | ☐ Yes | ◯ No | | | | | | |
| Uses a bottle | ☐ No | ◯ Yes | | | | | | |
| Healthy food and drink | ☐ Cereal with iron | ☐ Vegetables | ☐ Meat | ☐ Fruit | ☐ Fish | ☐ Water | ☐ Milk | |
| Nutritionally poor food and drink | ◯ Coke / soft drink | ◯ Junk food | ◯ Juice | ◯ Tea | ◯ Cordial | | | |
| Is the parent always able to provide the child with food? | ☐ Yes | ◯ No | | | | | Initial | Date |

## Social-emotional well-being

| | | | |
|---|---|---|---|
| Does the parent have concerns about any of the following? | Coping | ☐ No | ◯ Yes |
| | Relationships (family and social) | ☐ No | ◯ Yes |
| | Support | ☐ No | ◯ Yes |
| | Violence | ☐ No | ◯ Yes |
| | Child's behaviour | ☐ No | ◯ Yes |
| Observe: Is interaction between parent and child positive? | ☐ Yes | ◯ No | |
| If any concerns raised above, perform EPDS | Score | | Initial Date |

## Oral Health

| | | | | |
|---|---|---|---|---|
| Examination of teeth | ☐ Healthy | ◯ Decay | ◯ Malalignment | ◯ No examination |
| Examination of gums | ☐ Healthy | ◯ Bleeding | ◯ Red/swollen | ◯ No examination |
| Does the parent clean the child's teeth twice a day? | ☐ Yes | ◯ No | | Initial Date |

## Environment

| | | | | |
|---|---|---|---|---|
| Is the child exposed to cigarette smoke? | ☐ No | ◯ Yes | | |
| How many people live in the house? | | | | |
| Where does the child sleep? | ☐ Cot | ◯ Bed | ◯ Other | 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
- Infant 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

◀ DO NOT WRITE IN THIS BINDING MARGIN

| Family name: | Given name(s): | URN: |
|---|---|---|

## Note any required actions and transfer to care management plan

## Medicare

**Medicare item being claimed:**

Aboriginal and Torres Strait Islander child health assessment (715) ☐ 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 carer/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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

DO NOT WRITE IN THIS BINDING MARGIN ▶