



Medicare Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)

Child Health Assessment (0-14)

Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed in the Explanatory Notes for the health assessment found at www.health.gov.au/mbsonline. The first page of this form can be used as a report of the health assessment.

Patient's Name Male Female DOB: ____/____/____ or Age: ____
Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Current contact details

Address.....
Phone.....

Parent or carer's name/s.....
Alternative contact details.....
Address.....
Phone.....

Consent - Patient or Parent/Carer

Explanation of health assessment given Yes
Patient consent for health assessment given Yes
Date consent was given: ____/____/____

Consent given for information to be collected by

Registered Aboriginal health worker
Practice nurse

Previous health assessment

Has the patient had a previous health assessment?
No Yes

Date of last health assessment (if known) ____/____/____
Service provided by DR.....

PATIENT'S OVERALL HEALTH

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.....
.....

RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT OR PARENT/CARER

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.....
.....
.....

TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

TEST	AVAILABLE RESULTS & WHAT THEY MEAN

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STRATEGY FOR GOOD HEALTH: REQUIRED TREATMENT/SERVICES/HEALTH ADVICE

TREATMENT	HEALTH ADVICE	HEALTH SERVICES NEEDED

ACTION TO BE TAKEN BY PATIENT OR PARENT/CARER

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Next appointment with doctor:

Date: ___/___/___ Next Health Assessment: ___/___/___

GP: Dr GP's Signature: Date: ___/___/___

MEDICAL HISTORY as appropriate for age of patient

BACKGROUND INFORMATION - Child health record reviewed Yes

Mother's pregnancy	
Birth and neo-natal period	
Breastfeeding	
Weaning, food access and dietary history	
Development	
Previous presentations, hospital admissions and medication use	
Dental hygiene and access to dental services	
Educational progress	
Family relationships, social circumstances, caring arrangements	

CURRENT ISSUES	CURRENT RISK FACTORS

ALLERGIES/DRUG INTOLERANCE

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.....

CURRENT MEDICATIONS (including prescription and over the counter and supplied by doctor without prescription)

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.....
.....

RELEVANT FAMILY MEDICAL HISTORY

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.....
.....

IMMUNISATION STATUS (referring to current age/sex schedule)

TYPE	DATE	TYPE	DATE

NEONATAL HEARING SCREENING (any ISSUES identified)

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.....

PHYSICAL ACTIVITY

IDENTIFIED ISSUES	ACTION

NUTRITION

IDENTIFIED ISSUES	ACTION

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

IDENTIFIED ISSUES	ACTION

MOOD (depression and self harm risk)

IDENTIFIED ISSUES	ACTION

SEXUAL AND REPRODUCTIVE HEALTH

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL HISTORY AS INDICATED FOR PATIENT

Living conditions and exposure to environmental factors, including tobacco smoke

IDENTIFIED ISSUES	ACTION

Other history considered necessary by doctor or collector (including stressful life events)

IDENTIFIED ISSUES	ACTION

MEDICAL EXAMINATION

HEIGHT AND WEIGHT (plot and interpret growth curve/calculate BMI)

IDENTIFIED ISSUES	ACTION

NEWBORN BABY CHECK - if not previously completed

IDENTIFIED ISSUES	ACTION

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TEETH AND GUMS normal abnormal

IDENTIFIED ISSUES	ACTION

EAR AND HEARING: Otoscopy

IDENTIFIED ISSUES	ACTION

VISION (red reflex in newborn)

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL EXAMINATION – AS INDICATED FOR PATIENT

TRACHOMA (where indicated)

IDENTIFIED ISSUES	ACTION

SKIN (where indicated)

IDENTIFIED ISSUES	ACTION

RESPIRATORY EXAMINATION (if indicated)

IDENTIFIED ISSUES	ACTION

CARDIAC AUSCULTATION (if indicated) - congenital heart disease/rheumatic heart disease

IDENTIFIED ISSUES	ACTION

ASSESSMENT OF PARENT-CHILD INTERACTION (if indicated)

IDENTIFIED ISSUES	ACTION

DEVELOPMENTAL ASSESSMENT (age appropriate milestones) where appropriate

IDENTIFIED ISSUES	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED ISSUES	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS (eg referral details)
Haemoglobin testing	<input type="checkbox"/>	Date: ___/___/_____	
Audiometry	<input type="checkbox"/>	Date: ___/___/_____	
Other:.....			

ASSESSMENT OF PATIENT

(based on consideration of evidence from patient history, examination and results of any investigation)

EXISTING HEALTH ISSUES	IDENTIFIED RISK FACTORS

INTERVENTION ACTION

HEALTH ADVICE PROVIDED TO PATIENT OR PARENT/CARER

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OTHER ACTION (including referrals, liaison with school or family focussed and preventative health interventions)

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