



Facility:


**OUT OF HOME CARE PRIMARY
HEALTH SCREEN (2A):
UNDER 1 YR**

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Red flags  indicate need for further assessment or Comprehensive Health Assessment (2B).

To assist with the assessment, carers have been requested to complete relevant pages in the NSW Personal Health Record ("blue book") and bring this to the appointment


DETAILS OF THE CHILD

Country of birth	Preferred language: Interpreter Required: No <input type="checkbox"/> Yes <input type="checkbox"/> Type:
Refugee No <input type="checkbox"/> Yes <input type="checkbox"/>	Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Aboriginal and Torres Strait Islander <input type="checkbox"/> Neither Aboriginal or Torres Strait Islander <input type="checkbox"/>
Biological Family Health History	
Child's past and present health concerns (including pregnancy and birth information)	
Medications (name, dose frequency, include medication prescribed for neonatal abstinence syndrome )	


PHYSICAL HEALTH SCREEN

Immunisation status Up to date <input type="checkbox"/> Catch up required <input type="checkbox"/> (Include follow-up actions on Health Management Plan)
Allergies No <input type="checkbox"/> Yes <input type="checkbox"/> Specify:
Issues arising from physical health screen




PHYSICAL EXAMINATION

Length	cm centile	Weight	kg centile	Head circumference	cm centile
Growth concerns NO <input type="checkbox"/> YES <input type="checkbox"/> 					
Oral Health 'Lift the lip' check	No Concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/>	(refer to oral health)		
Hearing	No Concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/>	(refer to audiology)		
Vision	No Concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/>	(refer to eye specialist)		
Findings on physical examination					


DEVELOPMENTAL HEALTH SCREEN

Developmental concerns (carer and/or clinician)	No Concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/>
Specify:		
Ages and Stages Questionnaire	No concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/> 

PSYCHOSOCIAL AND MENTAL HEALTH SCREEN

Ages and Stages: Social and Emotional Questionnaire	No concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/> 
Relationship to carer:	No concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/> 
Emotional development (sleep, routines, settling, crying, feeding, separation issues)	No concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/> 

CARER CONCERNS REGARDING PLACEMENT

Carer wellbeing and capacity to meet the needs of the child/young person	No concerns <input type="checkbox"/>	Concerns exist <input type="checkbox"/> 
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COMPREHENSIVE ASSESSMENT REQUIRED YES Referral made to:

NO If no, please complete Health Management Plan (SMR060.720 (NH606661))

Assessment completed by: (Name and designation)	Signature:	Date:
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Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR060721

NH606662 200813

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UNDER 1 YEAR
SMR060.721