Queensland Government

Health Check 1 - 6 weeks

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 child had all age related eligible vaccines? ☐ Yes ○ No

Vaccines due _____

Initial Date

DO NOT WRITE IN THIS BINDING MARGIN

HEALTH CHECK 1–6 WEEKS

Family name:	Given name(s):	URN:

Birth parents's history

Both parents: Was this pregnancy planned?	☐ Yes	○ No	○ Not answered/asked
Both parents: Do you feel confident being a parent?	☐ Yes	○ No	○ Not answered/asked
Both parents: Have you ever been exposed to family violence as a child or now?	☐ No	○ Yes	○ Not answered/asked
Both parents: How many children are in your care?	_____		
Both parents: Did you smoke anything, drink alcohol, use drugs or prescription medicines before, during or after this pregnancy?	☐ No	○ Yes	○ Not answered/asked
Mother: Did mum have diabetes during this pregnancy?	☐ No	○ Yes	○ Not answered/asked
Mother: Did mum have a full STI screen?	☐ Yes	○ No	○ Not answered/asked

Initial Date

Birth information

Discharge summary received	☐ Yes	○ No	
Birth weight _____	Birth length _____		
Birth head circumference _____	Gestation _____		
Apgars 1 minute _____	Apgars 5 minutes _____		
Method of delivery	☐ SVD	○ Caesarean	○ Other
Newborn hearing test attended	☐ Yes	○ No	
Neonatal screening test (NNST) done	☐ Yes	○ No	
Was the baby treated for jaundice?	☐ No	○ Yes	
Did the baby have problems with breathing or convulsions at birth?	☐ No	○ Yes	
Was the baby ventilated?	☐ No	○ Yes	

Initial Date

Body measurements

Weight	_____ kg	(..... %le)	☐ Healthy	○ Underweight	○ Overweight
Length	_____ cm	(..... %le)	☐ Healthy	○ Other	
Head circumference	_____ cm	(..... %le)	☐ Normal	○ Other	
Anterior fontanelle	☐ Normal	○ Other _____			
Posterior fontanelle	☐ Normal	○ Other _____			

Initial Date

Clinical measurements

Breathing	☐ Normal	○ Other _____
Heart sounds	☐ Normal	○ Other _____
Femoral pulses	☐ Normal	○ Other _____

Initial Date

General appearance

Head and face			☐ Healthy	○ Other _____		
Limbs and joints	Hips abduct equally:		☐ Yes	○ No		
	Buttock creases equal:		☐ Yes	○ No		
Genitalia	Appearance:		☐ Normal	○ Other _____		
	Testes:	Left:	☐ Descended	○ Undescended	○ Not found	☐ N/A
		Right:	☐ Descended	○ Undescended	○ Not found	☐ N/A

Date Initial

Skin

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

Initial Date

Reflexes

Moro	☐ Present	○ Absent	Blink	☐ Present	○ Absent
Stepping	☐ Present	○ Absent	Grasp	☐ Present	○ Absent
Rooting	☐ Present	○ Absent	Plantar	☐ Present	○ Absent

Date Initial

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HEALTH CHECK 1–6 WEEKS

Eyes and vision

Eye appearance	☐ Normal	○ Other	Initial Date
Red eye reflex	☐ Present	○ Absent	

Ears and hearing

Did the baby have a newborn hearing screen?	☐ Yes	○ No	
Is the baby startled by loud noises such as a clap?	☐ Yes	○ No	
Has the baby been free of ear infections or discharge?	☐ Yes	○ No	Initial Date

Nutrition

Breast or formula feeding?	☐ Yes	○ No	
Any other food and drink?	☐ No	○ Yes	Initial Date

Physical activity

Does the baby do floor based play daily e.g. tummy time?	☐ Yes	○ No	Initial Date

Continence/ elimination

How many wet nappies does the baby have per day?	☐ Normal (5+)	○ Other	
Is the parent worried about the baby's bowel movements?	☐ No	○ Yes	Initial Date

Social-emotional wellbeing

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: _____		Initial Date

Environment

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	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
- » Support groups
- » Partner support and coping with baby
- » 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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