Queensland Government

Health Check 2 years

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 2 YEARS

Family name:	Given name(s):	URN:

Body measurements

Weight	kg	(..... %le) ☐ Healthy ○ Underweight ○ Overweight
Length	cm	(..... %le) ☐ Healthy ○ Other
Head circumference	cm	(..... %le) ☐ Normal ○ Other
BMI (once between 2½–3½)	kg/m²	(..... %le) ☐ Healthy ○ Underweight ○ Overweight

Initial Date

Clinical measurements

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

Initial Date

General appearance

Head, neck and face	☐ Healthy	○ Other _____
Limbs and joints	☐ Healthy	○ Other _____

Initial Date

Skin

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

Initial Date

Developmental milestones

Uses toys for their purpose e.g. cuddles a teddy rather than bangs, drops or throws toys	○ No	☐ Yes
Learning new words	○ No	☐ Yes
Puts words together e.g. push car	○ No	☐ Yes
Interested in self care skills e.g. feeding or dressing	○ No	☐ Yes
Walks independently	○ No	☐ Yes
Able to walk up and down stairs holding on	○ No	☐ Yes

If 'No' to any above, perform an ASQ or ASQ-TRAK and refer

Any parental concerns according to PEDS assessment? (See child's PHR booklet)	○ 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

If 'Yes' to any above, perform an ASQ or ASQ-TRAK and refer

Initial Date

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 happy with their child's speech or 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 (describe)	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

Environment

Is the child exposed to cigarette/vape smoke?	☐ No	○ Yes
How many people live in the house?	_____	
Any observed safety concerns?	☐ No	○ Yes

Initial Date

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Eyes vision	Fixates and follows an object	☐ Present	○ Absent	
	Corneal light reflex equal	☐ Present	○ Absent	Initial Date
Nutrition	Breast or formula feeding?	☐ Yes	○ No	
	Eating solids?	☐ Yes	○ No	
	Uses a cup or bottle?	☐ Yes	○ No	
	Healthy foods and drinks?	☐ Yes	○ No	
	Nutritionally poor foods and drinks?	☐ No	○ Yes	
	Does the child always have access to food?	☐ Yes	○ No	Initial Date
Oral health	Examine the gums and teeth. Adequate?	☐ Yes	○ No	
	Does the parent clean the child's teeth?	☐ Yes	○ No	Initial Date

Physical activity

Is the child physically active for > 3 hrs/day?	☐ Yes	○ No	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 child positive?	☐ Yes	○ No
	If any concerns raised above, perform SDQ	Score:	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
- » 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

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HEALTH CHECK 2 YEARS

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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