Queensland Government

Health Check 3 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 3 YEARS

Family name:	Given name(s):	URN:

Body measurements

Weight	kg	(..... %le) ☐ Healthy ○ Underweight ○ Overweight	
Length	cm	(..... %le) ☐ Healthy ○ Other	Initial Date
BMI (once between 2½–3½ years)	kg/m²	(..... %le) ☐ Healthy ○ Underweight ○ Overweight	

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

Interest in pretend play	○ No	☐ Yes
Notices and understands feelings in themselves and others e.g. happy or sad	○ No	☐ Yes
Familiar people understand child's speech	○ No	☐ Yes
Uses simple sentences e.g. big car go	○ No	☐ Yes
Matches similar coloured items	○ No	☐ Yes
Snips with scissors	○ No	☐ Yes
Imitates a person drawing a circle	○ No	☐ Yes
Runs, jumps, walks up and down stairs	○ No	☐ Yes
Balances on one foot for few seconds	○ 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, tympanometry (and audiometry if > 3½)

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
Audiometry (if > 3½)	Right ear:	4000Hz/25dB ☐ P ○ F 2000Hz/25dB ☐ P ○ F 1000Hz/25dB ☐ P ○ F
	Left ear:	4000Hz/25dB ☐ P ○ F 2000Hz/25dB ☐ P ○ F 1000Hz/25dB ☐ P ○ F

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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Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Eyes and vision

Cover test	Left eye movement:	Near: ☐ No	○ Yes	Far: ☐ No	○ Yes
	Right eye movement:	Near: ☐ No	○ Yes	Far: ☐ No	○ Yes
Visual acuity (with glasses? ☐ Yes ☐ No)		Right: /	Left: /	☐ 6/9 or less	○ Other (> 6/12)
Red eye reflex		☐ Present	○ Absent		
Fixates and follows an object		☐ Present	○ Absent		

Initial Date

Nutrition

Breast or formula feeding?	☐ Yes	○ No
Eating solids?	☐ Yes	○ No
Uses a bottle?	☐ No	○ Yes
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
- » Child 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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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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