



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		

Facility:

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

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 Catch up required (Include follow-up actions on Health Management Plan)

Allergies No Yes Specify:

Issues arising from physical health screen

PHYSICAL EXAMINATION

Length	cm centile	Weight	kg centile	Head circumference	cm centile
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Growth concerns NO YES

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)



SMR060721

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

NH60662A 190416

OUT OF HOME CARE PRIMARY HEALTH SCREEN:
UNDER 1 YEAR
SMR060.721



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

D.O.B. ___ / ___ / ___ M.O.

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

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Findings on physical examination

DEVELOPMENTAL HEALTH SCREEN

Developmental concerns (carer and/or clinician) **No concerns** **Concerns exist** Specify:

Ages and Stages Questionnaire **No concerns** **Concerns exist**

PSYCHOSOCIAL AND MENTAL HEALTH SCREEN

Ages and Stages: Social and Emotional Questionnaire **No concerns** **Concerns exist**

Relationship to carer: **No concerns** **Concerns exist**

Emotional development (sleep, routines, settling, crying, feeding, separation issues) **No concerns** **Concerns exist**

CARER CONCERNS REGARDING PLACEMENT

Carer wellbeing and capacity to meet the needs of the child/young person **No concerns** **Concerns exist**

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: print and sign

Date:

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

