



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): 1-5 YEARS

This form provides a guide to ensure all domains of health are addressed in the Primary Health Screen (2A). Red flags indicate the 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 emotional or behavioural reasons)

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

Height	cm centile	Weight	kg centile	Head circumference	cm centile	BMI (over 2 years)
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)			



SMR060722

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

NH60663 130314

OUT OF HOME CARE PRIMARY HEALTH SCREEN:
1-5 YEARS
SMR060.722



FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

D.O.B. ____/____/____

M.O.

Facility:

ADDRESS

OUT OF HOME CARE PRIMARY HEALTH SCREEN (2A): 1-5 YEARS

LOCATION / WARD

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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 (behaviour, routines, sleep, self-regulation, social, 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:

Date:

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