Queensland Government

Health Check 18 months

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 18 MONTHS

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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
Anterior fontanelle		☐ Normal ○ Other

Initial Date

Clinical measurements

Breathing	☐ Normal	○ Other
Heart sounds	☐ Normal	○ Other
Haemoglobin	_____ g/L	

Initial Date

General appearance

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

Skin

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

Initial Date

Developmental milestones

Shows interest in playing and interacting with others?	○ No	☐ Yes
Clear words spoken?	○ No	☐ Yes
Understands short requests e.g. where is the ball?	○ No	☐ Yes
Scribbles with a crayon?	○ No	☐ Yes
Attempts to stack blocks after demonstration?	○ No	☐ Yes
Attempts to walk without support?	○ No	☐ Yes
Stands alone?	○ 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

Physical activity

Is the child physically active for > 3 hrs/day?	☐ Yes	○ No	Initial Date

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Eyes vision	Fixates and follows an object	☐ Present	○ Absent		
	Red eye reflex	☐ 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	Does the child have any teeth?	☐ Yes	○ No		
	Examine the gums and teeth. Adequate?	☐ Yes	○ No		
	Does the parent clean the child's teeth?	☐ 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 baby positive?	☐ Yes	○ No		
	If any concerns raised above, perform SDQ	Score: _____		Initial	Date
Environment	Where does the child sleep?	☐ Cot	○ Other		
	Is the child placed on their back to sleep?	☐ Yes	○ No		
	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

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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