

**Medicare Healthy Kids Check MBS Items 709 and 711**

**Patient Details:**

<b>Patient's Name:</b>		<<Patient Demographics:Full Name>>	
<b>DOB:</b> <<Patient Demographics:DOB>>	<b>Age:</b> <<Patient Demographics:Age>>	<b>Gender:</b> <<Patient Demographics:Sex>>	
<b>Address:</b>	<<Patient Demographics:Address>>	<b>Phone:</b>	<<Addressee:Phone>>
<b>Career's Name:</b>		<b>Phone:</b>	
<b>Person responsible/legally appointed Guardian (Name/relationship/contact details):</b>			
<b>Previous health check</b> – Has the patient had a previous health assessment?		◆ Yes ◆ No	
<b>Service provided by Dr.:</b> <<Doctor:Name>>			

**Healthy Kids Check:**

Explanation of Healthy Kids Check given: ◆ Yes ◆ No

Patient/Guardian consent for check given: ◆ Yes ◆ No

Date consent given: <<Miscellaneous:Date>> Signature of Parent/Guardian: \_\_\_\_\_

Consent recorded by: \_\_\_\_\_

**Get Set 4 Life – habits for healthy kids:**

Get Set 4 life provided to Parent/Guardian: ◆ Yes

Date Provided: <<Miscellaneous:Date>> Signature of Parent/Guardian: \_\_\_\_\_

**Four year Old Immunisation:**

Consent for immunisation given: Yes TT

Date consent given: \_\_\_\_\_

Signature of Parent/Guardian authorising consent for immunisation: \_\_\_\_\_

If immunisation previously given note evidence: \_\_\_\_\_

Personal Health Record: Yes TT

Other: \_\_\_\_\_

**Immunisations:**

<<Clinical Details:Immunisation List>>			
Vaccine	Batch No.	Date Given	Signature Stamp
Diphtheria, tetanus, pertussis			
Polio			
Measles, mumps, rubella			
<b>Recommendations/Actions:</b>			

**Patient History**

**Medical History:** <<Clinical Details:History List>>

**Family History:** <<Clinical Details:Family History>>

Family Relationships: \_\_\_\_\_

Care arrangements: \_\_\_\_\_

**Allergies:** <<Clinical Details:Allergies>>

**Health Issues Identified and Discussed With Patient and/or Care:**

**Medication Review**

**Current Medications:** <<Clinical Details:Medication List>>

Other Medications: (including non-prescription medicines, prescriptions from other doctors, etc)

Medication Issues:	Recommendations/Actions:
(e.g. continuing need, dose/frequency formulation, duplication, contraindications, adverse effects, drug interaction, compliance etc)	(e.g. dose change, cease, new medication, medication counselling, compliance aids etc)

**Social wellbeing:**

<<Clinical Details:Social History>>

Paediatrician: \_\_\_\_\_

Previous Presentations: \_\_\_\_\_

**Lifestyle**

**Diet/Nutrition**

discuss the child's appetite  
questioning about the variety of foods the child eats  
discussing the frequency of consuming processed foods

◆ Exclusions e.g. wheat free, dairy free  
◆ No special diet  
◆ Dietary advice given

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Physical activity**

discuss the time spent in active or energetic play  
discuss the time spent on sedentary activities

Type: \_\_\_\_\_

Times per week: \_\_\_\_\_

◆ Physical activity advice given

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Physical Examination**

**Weight:** <<Clinical Details:Measurements>> **Height:** <<Clinical Details:Measurements>>

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Oral Health (including but not limited to):**

◆ Dental problems Last dental assessment: \_\_\_\_\_

◆ Advice given about oral health ◆ How often the child brushes their teeth

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Hearing (including but not limited to):**

◆ Ear examination - Ear canals clear: ◆ Yes ◆ No - Whispered words at 3m: ◆ Yes ◆ No

◆ History of ear infections, ear discharge, recurrent or chronic otitis media or other problems

Last audiometry: ◆ Normal ◆ Abnormal ◆ N/A

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Eyesight (including but not limited to):**

◆ Visual inspection of the eyes

◆ LEA Children's Chart, or similar, if appropriate

◆ parental/other concerns about vision (eg. amblyopia, squint, infection, injury)

◆ family history of eyesight problems

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**Toilet Habits (including but not limited to):**

Requires toilet assistance: ◆ Yes ◆ No

Wetting accidents: ◆ Yes ◆ No

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

**ADDITIONAL MATTERS FOR CONSIDERATION (Non-mandatory from this point onward):**

The health check might include the following matters, at the discretion of the GP/practice nurse and according to his or her clinical judgement. It may be useful to refer to the patient's State/Territory personal health record and the Guide.

**General wellbeing**

**Behaviour and mood – including but not limited to**

sleeping  
energy levels  
social and emotional well-being  
ability to separate from main carer

**Notes/Identified Issues:** \_\_\_\_\_

**Recommendations/Actions:** \_\_\_\_\_

<b>Speech and language development – including but not limited to:</b>	
Seek parent/guardian concern about: the number of words their child uses or their understanding of direction whether/their child speaks clearly and takes an active part in conversations	Identified Issues:
<b>Notes/Identified Issues:</b>	
<b>Recommendations/Actions:</b>	

<b>Fine and motor skills – including but not limited to:</b>	
Picking up small objects walking, running, jumping, hopping, climbing stairs drawing without scribbling riding a tricycle	Identified Issues:
<b>Notes/Identified Issues:</b>	
<b>Recommendations/Actions:</b>	

<b>Other examinations considered necessary by GP/Practice nurse:</b>		
Examinations	Identified Issues	Action
<b>Notes/Identified Issues:</b>		
<b>Recommendations/Actions:</b>		

**Summary and Recommendations and Actions**

Problems / Needs / Risks	Recommendations/Actions (e.g. investigations, reviews, referrals, etc.)

**OTHER RECOMMENDATIONS:**

**PATIENT'S OVERALL HEALTH STATUS:**

<<Doctor Name>> (GP or Practice nurse)	
Signature: _____	Date: <<Miscellaneous Date>>
If the check has not been conducted at the patient's usual medical practice, a copy of the record is to be sent to:	
Name of 'usual' GP/Practice: _____	
Parent/Guardian consent to provide a copy: _____	
Date: <<Miscellaneous Date>>	