Form IHA - YP LOOKED AFTER CHILDREN

Initial Health Assessment

recommended for young people 10 years and older

Part B to be completed by examining health professional **CONFIDENTIAL**

This information is confidential and is not to be divulged without authorisation of the Health Adviser. For adoption only, a copy of this entire form will be sent to the young person's adoption agency.

The young person should be accompanied by his/her carer and if possible a birth parent, provided, where he/she has capacity to consent, he/she agrees to be accompanied. Valid consent to health assessment is needed from the young person who has capacity, and only if he/she does not have capacity, from an adult with parental responsibility/ies. For consent to access family health information a signed Consent Form (or photocopy) must be attached.

Part A To be completed by the agency – write clearly in black ink

Form to be returned to the agency Health Adviser:

Name	Dr J Gould		
Address **Postcode**	Pelhams Clinic Millhams Road Bournemouth BH10 7LH		
Telephone	01202 570821	**Fax**	01202 576104
Email			

Young Person		**Interpreter/signer required?**	**Arranged?**
		Yes / No	Yes / No

First name(s)		**Family name**	
Likes to be known as		**Also / previously known as**	
Date of birth		**Sex M/F**	
Legal status eg. In care/ accommodated supervision order (Scotland)		**NHS number** **CHI number (Scotland)**	
Person(s) with parental responsibility/ies:		**Current legal proceedings**	
Date first looked after at this episode		**Reason for being looked after**	
Number of previous carers, including birth family			
Ethnicity/religion			
First language		**Other language(s)**	
School/other care	S		

Birth family

Mother:	**Name**	
Address		

Name of young person		DoB	

Postcode		Telephone	
Ethnicity/religion/first language			
Contact arrangements			
Father: Name			
Address			
Postcode		Telephone	
Ethnicity/religion/first language			
Contact arrangements			
Siblings contact arrangements			
Any previous birth family name/address?			

Name of GP

Name and Address			
Postcode		Telephone	

Current carers

Name		Length of time provided care	
Address			
Postcode		Telephone	Any relationship to the young person?
Languages spoken			

GP of carers (if different from above)

Name			
Address			
Postcode		Telephone	

Agency details

Name of agency		Name of social worker	
Address			
Postcode		Telephone	

Consent by birth parent/social worker* where young person does not have capacity to consent

Consent already given in Looked After documents? Yes					
I agree to		being assessed		Date	
Signature		Name		Relationship	
* Authorised by LA to give consent on their behalf					
Part A completed by:		Telephone		Date	

Name of young person		DoB	

Part B To be completed by the examining health professional and retained within the young person's health record.

Consent by the young person with capacity to consent is essential. Does the young person have capacity to consent? Yes/No
If not, then check for signed consent in Part A

Consent by the young person	
I understand the need for this health assessment and I agree to be seen. I understand that following this assessment, a summary and recommendations for my health care plan will be drawn up. A copy of this will be given to me and my social worker. I consent to copies being sent to my carer, birth parent(s), GP and school nurse/doctor (delete or add as necessary).	
Signature See separate sheet	**Date**

List those present at assessment:

1. Health discussion

How are you feeling today? What would you like to get from this health assessment?
Do you have any worries about your health? Are you eating and sleeping well?
How are you getting on at school? Do you attend regularly? Favourite subjects? Any special educational needs? Do you have friends at school? Are you being bullied? Are you a bully?
What are your interests, activities and hobbies?
Do you wear glasses? Any concerns about eyesight? When was it last tested?
Do you have any concerns about hearing? Would you like it tested?

Name of young person		DoB	

Are you attending any health or therapy appointments? Are there any outstanding? Yes

	Name	Address	Give details/dates of last visit
School Nurse			
Dentist			
Paediatrician			
CAMHS			
Other			

Would you like any further discussion or any information about skin or hair care, diet, exercise, relationships, sex, smoking, alcohol, street drugs, etc?
Do you have a trusted adult to talk to?
Any other concerns (from social worker, birth parent, carers, school, etc)?

2. Immunisation status

		Dates given				
Is this young person fully immunised for their age? Yes/ **Immunisations required:**		**1**	**2**	**3**	**4**	**5**
	Diphtheria					
	Tetanus					
	Pertussis					
	Polio					
	HiB					
	Meningitis C					
	MMR					
	Hepatitis B					
	BCG					
	Pneumococcus					
	HPV					
	Other					

3. Health history

Name of young person		**DoB**	

Family health history including genetic disorders, mental health and learning difficulties taken from Form PH or, if different, state source. Please indicate if no family history is available	
Mother	
Father	
Siblings	
Others	
Social and care history including lifestyle issues, and any risk of blood-borne viruses or other infections	
Personal health history including summary of Forms M & B where available	
a. Antenatal and birth, including risk-taking behaviour, time and place of birth, birth measurements, resuscitation required, Apgar scores	
b. Neonatal, including feeding details and attachment	
c. **Other** past health history including growth, illnesses, hospital admissions and accidents	
Regular medication/equipment required	
Allergies/adverse reactions to medication, food or animals	

Investigations	**Date**	**Result**

Name of young person		**DoB**	

Thyroid function and PKU		
Haemoglobinopathy screen		
Cystic fibrosis		
Hepatitis B		
Hepatitis C		
HIV		
Genetic/chromosomes		
Other		

4. Physical examination

Date		**Age**	

General appearance/presentation including evidence of non-accidental injury

Skin, including BCG scar			
Hair colour		Eye colour	
Oral health			

Growth

Height		Centile	**Weight**		centile	**OFC**	cm	centile

ENT Result & date of last hearing test

Eyes

Red reflex/cover test	
Result & date of orthoptic assessment/visual acuity test	

Respiratory system Does anyone in the carer's household smoke?

Chest clear

Cardiovascular system

Abdomen

Pubertal status (NB. assess during examination and examine genitalia *only* if clinically indicated)

Name of young person		**DoB**	

Date of menarche	
Nervous system (as clinically indicated, including fine and gross motor skills and co-ordination)	
Musculoskeletal system (NB. scoliosis and other joints as clinically indicated)	

5. Emotional and behavioural development (including Carer's Report and Strengths and Difficulties Questionnaire when available)

6. Current functional assessment

Date		**Age**	
Attention and concentration			
Conclusion			
Communication skills			
Conclusion			
Self-care skills (dressing, personal hygiene, toileting, etc)			
Conclusion			

Name of young person		**DoB**	

Independence skills in daily living (telling time, handling money, preparing simple food, road safety, stranger awareness)	
Conclusion	
Social and peer relationships	
Conclusion	

7. Special educational needs/additional support needs for learning

School action?	
School action plus?	
Statement of SEN/Record of needs/Co-ordinated support plan?	
Concern about attendance?	
Is recent school report available?	

Examining health professional

Signature		**Date**	
Name	Dr J Gould		
Designation	Medical Examiner	**Address**	Pelhams Clinic Millhams Road Kinson
Qualifications	BM BS Bsc MRCGP		
GMC registration number (doctors only)			
Telephone	01202 570821	**Postcode**	BH10 7LH
Email		**Fax**	01202 576104

It is essential that the examining health professional discuss the issues raised in this report with the young person, and seek appropriate consent for further dissemination of information. The examining health professional or agency Health Adviser should discuss the issues and their implications for the young person with any future carers.

Please respect confidentiality and take care whether or not to share personal health information.

Name of young person		DoB	

Part C should be retained in the young person's heath record and a copy sent to the social worker. It is good practice, with appropriate consent, to share this information with the young person's current and future carers. This summary should also be shared with adoption and fostering panels. For adoption only, a copy of this entire form will be sent to the young person's adoption agency.

SUMMARY REPORT FROM AGENCY HEALTH ADVISER

Date completed	

Relevant family history (state source) **and implications for future**

Mother		Father	
Siblings		Other	

Relevant factors in young person's own health history and implications for future

Birth history and past health history

Present physical and dental health

Weight		Centile	Height		Centile	BMI

Immunisations

Two months; DTap/IPV/Hib Pneumococcal (PVC) Rotavirus	**Date given:**	**Three month; DTaP/IPV/Hib Men C Rotavius**	**Date given:**
Four Months; DTaP/IPV/Hib and PVC	**Date given:**	**Between 12 and 13 months Hib/Men C/PVC and MMR**	**Date given:**
2 and 3 yrs; Influenza	**Date given:**	**3yrs 4months dTaP/IPV or DTaP/IPV MMR**	**Date given:**

Developmental and educational history

Emotional and behavioural development

Name of young person		DoB	

Sexual health and lifestyle issues
Parenting issues in current placement
Issues will be reviewed by your social worker at your statutory review with your permission. Personal or sensitive health topics should not be discussed in a group setting. If you need help with these, please ask the help of your carer, social worker, or health professional.

HEALTH RECOMMENDATIONS FOR YOUNG PERSON CARE PLAN

Name of young person		**DoB**	

Personal or sensitive health topics should not be put in this plan or discussed in group settings without the express knowledge and consent of the young person.

Date of next health assessment	

Issues	**Action required**	**By when**	**Named person responsible**	**Action taken/Date Completed**

Allergies			
Immunisations up to date?			
Registered with GP?			
Permanently registered with GP?		**Name**	
Registered with dentist?		**Name**	

All issues to be reviewed by social worker at Looked After Young Person Reviews

Name of person completing Part C	Dr J Gould	**Date**	
Designation	Medical Advisor	**Address**	Pelhams Clinic Millhams Road Bournemouth BH10 7LH
Qualifications	BM BS Bsc MRCGP		
Postcode	BH10 7LH		
Telephone	01202 570821		
Fax	01202 576104		
Email			

Signature	**Panel:**