

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	Pelhams Clinic Millhams Road Bournemouth BH10 7LH		
Postcode	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	
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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	
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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?

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Do you have a trusted adult to talk to?

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Any other concerns (from social worker, birth parent, carers, school, etc)?

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2. Immunisation status

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

3. Health history

Name of young person		DoB	
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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
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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 <i>only</i> 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)

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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 MRCP		
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	
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Part C should be retained in the young person’s health 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	
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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

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Present physical and dental health

Weight		Centile	Height		Centile	BMI
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Immunisations			
Two months; DTap/IPV/Hib Pneumococcal (PVC) Rotavirus	Date given:	Three month; DTaP/IPV/Hib Men C Rotavirus	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	
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Sexual health and lifestyle issues

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Parenting issues in current placement

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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.

Name of young person		DoB	
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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	
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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 MRCP		
Postcode	BH10 7LH		
Telephone	01202 570821		
Fax	01202 576104		
Email			
Signature	Panel:		