Form IHA – C LOOKED AFTER CHILDREN

Initial Health Assessment

recommended for children from birth to 9 years

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 child should be accompanied by his/her carer and if possible a birth parent. Valid consent to health assessment is needed from an adult with parental responsibility/ies, unless the child has capacity to consent for him/herself. 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:

Health Adviser' s Name	Dr Judith GOuld		
Address and Postcode	Pelhams Clinic Millhams Road Kinson BH10 7LH		
Telephone	01202 570821	**Fax**	01202 576104
Email			

Child		**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/nursery/other day care			

Name of child		**DoB**	

Birth family

Mother:	**Name**			
Address				
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 child?**	
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 child does not have capacity to consent

Consent already given in Looked After documents? Yes / No If not, then complete below					
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 child		DoB	

Part B To be completed by the examining health professional and retained within the child's health record. For adoption only, a copy of this entire form will be sent to the child's adoption agency.

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

Consent by the child	
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). **In adoption, I understand a copy of this entire form will be sent to my adoption agency** (delete if not applicable).	
Signature	**Date**

List those present at assessment:

1. Health discussion

Is the child currently well and enjoying life? Does the carer have any concerns about the child's health or well being?
Does the child eat and sleep well?
Are there any concerns about development or school progress? **Are self-care skills (including toileting) age-appropriate?**
Are there any significant behaviour problems or difficulty relating to carers, other significant adults and peers?

Is the child attending any health or therapy appointments? Are there any outstanding?

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

Name of child		**DoB**	

Would it be appropriate for the child to have any further discussion or information about skin or hair care, diet, exercise, relationships, sex, smoking, alcohol, street drugs, etc?
Does the child have a trusted adult to talk to?
Any other concerns (from social worker, birth parent, carers, school, etc)?

2. Immunisation status

		Dates given				
		1	**2**	**3**	**4**	**5**
Is this child fully immunised for their age?	**Diphtheria**					
	Tetanus					
Yes/No	**Pertussis**					
	Polio					
	HiB					
Immunisations required:	**Meningitis C**					
	MMR					
	Hepatitis B					
	BCG					
	Pneumococcus					
	Other					

3. Health history

Family health history including genetic disorders, mental health and learning difficulties 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/birth, including risk-taking behaviour, time and place of birth, birth measurements, resuscitation required, Apgar scores	

Name of child		**DoB**	

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**
Thyroid function		
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**	

Name of child		**DoB**	

Oral health	

Growth								
Height	cm	centile	**Weight**	kg	centile	**OFC**	cm	centile

ENT Result & date of neonatal/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?

Cardiovascular system

Abdomen

Genitalia (NB. **only** where clinically indicated)

Nervous system (as clinically indicated)

Musculoskeletal system (NB. hip stability, scoliosis, etc)

5. Emotional and behavioural development (including Carer's Report)

Name of child		**DoB**	

6. Developmental/functional assessment

Date		**Age**	
Gross motor skills			
Conclusion			
Fine motor skills and eye-hand coordination			
Conclusion			
Communication skills			
Conclusion			
Cognitive skills and level of attention			
Conclusion			
Social and self-care skills including toileting			
Conclusion			
Date and results of any formal developmental assessment (eg SoGS, Griffiths)			

7. Special educational needs/additional support needs for learning

Is the child likely to require extra help in school?	Yes/No/Possibly
Notification to the Local Education Authority/Education Department?	Yes/No
School action?	Yes/No
School action plus?	Yes/No
Statement of SEN/Record of needs/Coordinated support plan?	Yes/No

Name of child		**DoB**	

Examining health professional

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

It is always good practice for the examining health professional to discuss the issues raised in this report with the child, where it is age appropriate, and to 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 child with any future carers.

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

Name of child		**DoB**	

Part C should be retained in the child's health record and a copy sent to the social worker. It is good practice, with appropriate consent, to share this information with the child'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 child'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 child'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 child		**DoB**	

Parenting issues in current placement

Name of child		**DoB**	

HEALTH RECOMMENDATIONS FOR CHILD CARE PLAN

Date of next health assessment	

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

Allergies	Yes/No		
Immunisations up to date?	Yes/No		
Registered with GP?	Yes/No		
Permanently registered with GP?	Yes/No	**Name**	
Registered with dentist?	Yes/No	**Name**	

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

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