

Pt ID: _____

Older Person (55+) Health Check for Marumali Patients

ATSI 55+ years old : Item 704 Surgery /706 Home

It is recommended that previous patient files be obtained & examined prior to assessment

Case manager (AHW): _____

Date initiated: _____

PATIENT DETAILS	MEDICAL PRACTITIONER DETAILS
Marumali Pt ID: Name: Date of Birth: Sex: Address: Phone:	Name: Address: Patient Medicare No: Exp: Health Care Card? Yes / No If yes - Number: Start date: Exp date:

Is the patient Aboriginal and/or Torres Strait Islander?	Yes / No
Has the patient undertaken a Health Assessment in past 2 years?	Yes / No
If previous Health Assessment, what was the date of the assessment?	
Health insurance? (optional to answer) Yes / No	
(If relevant) Patient's Carer:	ATSI: Yes/No

MEDICAL HISTORY & CURRENT HEALTH PROBLEMS				
What is the Patient's estimate of their health?	Very Good	Good	Fair	Poor
When was your last visit to your GP? What was this for?				
Past/current medical history (tick & provide details of any past/current conditions)				
<input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> High cholesterol <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiovascular (Heart) problems <input type="checkbox"/> Renal (kidney) problems <input type="checkbox"/> Liver disease <input type="checkbox"/> Pulmonary (lung) problems (inc. asthma) <input type="checkbox"/> Cancers <input type="checkbox"/> Eyesight <input type="checkbox"/> Hearing <input type="checkbox"/> Dental (teeth/mouth) <input type="checkbox"/> Other?				
Drug & Alcohol				
How much alcohol do you drink? ___u/ day / ___u/ week / ___u/month / None				
How many cigarettes do you smoke? _____Per day /Ex-smoker /Non-smoker				
Do you use any other substances? How often?				

CURRENT MEDICATIONS – Prescribed and Non-Prescribed

Medications <i>Including over the counter and supplements</i>	Dose/frequency	Actual use by patient	Reason for medication

Do you have any allergies?	Yes / No
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FAMILY MEDICAL HISTORY**Is there a family history of the following:**

Diabetes?	Yes / No
Heart Disease?	Yes / No
Pulmonary Disease?	Yes / No
Prostate / Breast / Bowel Cancer?	Yes / No

Any other relevant family medical history?**SOCIAL HISTORY**

Who do you live with? <i>details</i>	
Number _____	
Do you look after other people?	Yes / No <i>If yes: whom/details?</i>
Does anyone look after you?	Yes / No
Is someone available if you want help/support?	Yes / Sometimes / No
Are you working?	Yes/No Full Employment / Part Employment / Unemployed / Self funded Retiree / Pensioner
Occupation?	<i>details</i>
Are you studying?	Yes/No At School / TAFE / University / Other Education
Other Details?	
HOME ENVIRONMENT	
Do you own your own home?	Own Home / Renting Private/ Renting public housing / AHO / Free Lodging
Does everything in your house work? (include water, stove, lights, toilet, heater) <i>If not, provide details.</i>	

NUTRITION

How healthy would you say your diet and the food in your home is?	Very Healthy / Usually Healthy / Sometimes Healthy / Not very Healthy
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Do you eat three meals most days?	Yes / Sometimes/ No
Do you eat fruit and vegetables most days?	Yes / Sometimes/ No
Do you eat diary products most days?	Yes / Sometimes /No
Do you drink 6-8 cups of fluids most days?	Yes / Sometimes / No
<i>What would be a normal meal / day for you?</i>	
Any special dietary needs?	Yes / No Details
Would you say you are underweight / average / slightly overweight / very overweight ?	
Other Details?	

ACTIVITIES OF DAILY LIVING & EXERCISE

How far are you able to walk without resting?	1 km easily / Up 7 steps / Down 7 steps	
Do you exercise for minimum 30 mins per day?	Yes / No	
How many days of the week?	1 2 3 4 5 >5 days of the week	
<i>Do you have problems with any of the following activities:</i>		
Dressing? Yes / No	Using the toilet? Yes / No	Using the phone? Yes / No
Washing? Yes / No	Reading? Yes / No	Other?
<i>If answered "yes" to any of the above:</i>		
Do you have assistance with home care?	Yes / No <i>Details:</i>	
Do you require assistance with homecare?	Yes / No <i>Details:</i>	
Other Details?		

EMOTIONAL HEALTH & WELLBEING – still being edited

Do you feel sad or worried?	A lot of the time / Sometimes / No	
Do you feel anxious?	A lot of the time / Sometimes / No	
Have you ever felt hurt, harassed, or intimidated by someone close to you?	Yes / No <i>Details</i>	
Have you hurt yourself recently, or thought about it?	Yes / No <i>Details</i>	
Are you sleeping okay? Yes/ No	Hard to fall asleep / wakes during night / wakes early in morning / No problems	
Other Details?		

SEXUAL & REPRODUCTIVE HEALTH

<i>Female:</i> Have you had a papsmear within the last two years? Have you had a mammogram within the last two years? <i>(note, this is recommended for those aged 50-69 years)</i>	Yes / No (specify date) Yes / No (specify date)
<i>Male:</i> Have you ever had a prostate examination (DRE or PSA blood test)? <i>If not, have you discussed prostate cancer screening with your GP?</i>	Yes / No (specify date) Yes / No
Have you discussed with your doctor about STDs?	Yes / No
Other Details?	

IMMUNISATION STATUS

Pt ID: _____

Did you receive your childhood vaccinations (2months – 4 years)? <i>this will vary with age of the person, but could include polio, DTP (diphtheria, tetanus, pertussis), MMR (measles, mumps, rubella), Hepatitis B, etc.</i>	Yes / No / Unsure
Influenza and Pneumococcal vaccines? <i>For 15-49 year olds at risk (due to other medical condition e.g. asthma) Or >50 years of age (everyone)</i>	Yes / No / Unsure

GP APPOINTMENT made on (date):	Date/time of appointment:
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Written resources provided (please tick)		
<input type="checkbox"/> Quit smoking	<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Physical Activity	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Other drugs	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Sexual Health
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Stroke	<input type="checkbox"/> other _____

Section completed: _____
(Health worker to sign)

Section reviewed by GP: _____
(GP to sign)

THE FOLLOWING SECTION MAY BE COMPLETED BY A PRACTICE NURSE OR THE GP:**PHYSICAL EXAMINATION**

Height:	Cms	BMI:	
Weight:	Kgs	Waist Circumference:	Cms

Blood Pressure:		Pulse Rate & Rhythm:	
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Visual Acuity: Especially if over 40 years	Left		Unaided / With Glasses
	Right		Unaided / With Glasses

Hearing: Whisper Test	Left	
	Right	

Urinalysis:	Protein:	Glucose:	Other:
Random BSL:			

Spirometry: If patient has history of asthma/COPD/smoking	PEFR	
	VFT pre ventolin	
	VFT post ventolin	

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE GENERAL PRACTITIONER:**PATIENT CONSENT**

My GP has explained to me the purpose of an Adult Health Assessment and its likely benefits to me as a patient.

Patient Signature:	Date:
Or verbal consent given?	Yes / No
Has the patient requested the withholding of any data? (If yes, give details)	Yes / No

Medication Review completed by GP? Consider continuing appropriateness, duplication, contraindications, drug interactions, adverse effects, serum levels / biochemistry required and adherence.	Yes / No
Consider referral for Home Medicine Review?	Yes / No

OTHER DOCTORS and ALLIED HEALTH WORKERS INVOLVED IN CARE

	Current	Recommended		Current	Recommended
Aboriginal Health Worker	yes	-	Audiologist		
Practice Nurse			Optometrist		
Community Nurse			Dietician		
Educator			Nutrition Program		
Physiotherapist			Exercise Program		
Occupational Therapist			Community Services		
Dentist			Mental Health		
Vascular Health			Social Worker		
Podiatrist			Men / Women's Group		
Youth Group			Drug / Alcohol Counsellor		
Specialist			(specify)		
Other			(specify)		

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**Recommendations from 55+ Health Check
(Copy to be provided to patient and to Marumali)**

Pt Id (Marumali to enter):

Doctor:

Patient Name:

Date:

Date Of Birth:

Adult Health Assessment Checklist:	
Assessment of risk factors and investigation results discussed with patient?	Yes / No
Health Assessment recommendations discussed with patient?	Yes / No
ATSI Adult Health Assessment (Item 710) billed?	Yes / No
ATSI Adult Health Assessment placed into recall system for 18 months time?	Yes / No
Review date for GP to initiate interventions placed into recall system?	Yes / No
Issues and recommendations transferred to GP Only Care Plan? MBS Item 721	Yes / No
Issues and recommendations transferred to GP Team Care Plan? MBS Item 723	Yes / No

Area	Problem Identified	Action proposed
Current /Past History		
Family History		
Social Situation		
Home Environment		
Nutrition		
Activity of daily life / Exercise		
Mental Health		
Smoking		
Alcohol / Substance Use		

Violence		
Sexual / Reproductive Health		
Medications		
Immunization Status		
Physical Examination (inc. cardio, resp., abdomen/GI, urinary tract, neruo, musculoskeletal, skin, ears, oral health, and anything else deemed relevant)		
Investigations (may inc. haemoglobin, cholesterol, triglycerides, BSL, renal function, liver function, HbA1C if diabetic, STD screening, occult blood >50 years, etc)		
Specialist Referrals		
Allied Health Referrals		
Other Issues		