Form IHA – C

MEDICAL REPORT & DEVELOPMENTAL ASSESSMENT
OF CHILD UNDER 10 YEARS LOOKED AFTER OR

REFERRED FOR ADOPTION

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BAAF, Skyline House, 200 Union Street, London SE1 OLX.Form IHA – C LOOKED AFTER CHILDREN CONFIDENTIAL

# baaf logoInitial Health Assessment

# recommended for children from birth to 9 years

# To be completed by a doctor

**This information is confidential and is not to be divulged without authorisation of the Health Adviser.**

**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:

|  |  |
| --- | --- |
| Name  |       |
| Address       Postcode       |
| **Telephone** |       | **Fax**  |       |
| **Email** |       |

##

|  |  |  |
| --- | --- | --- |
| **Child** | Interpreter/signer required?  | Arranged? |
|       |       |       |
| First name(s) |       | Family name |       |
| Likes to be known as |       | Also / previously known as |       |
| Date of birth  |       | Gender |        |
| Legal statuseg. In care/accommodatedsupervision 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 |       |

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### Page 3

|  |  |  |  |
| --- | --- | --- | --- |
| Name of child |       | DoB |       |

|  |
| --- |
| Birth family |
| Mother: Name       | Siblings contact arrangementsAny previous birth family name/address? |
| Address       |       |
| Postcode       | Telephone       |
| Ethnicity/religion/first language       |
| Contact arrangements       |
|  |
| Father: Name       |
| Address       |
| Postcode  | Telephone       |
| Ethnicity/religion/first language       |
| Contact arrangements       |

|  |  |
| --- | --- |
| Name of GP |       |
| 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       |

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### Page 4

|  |  |
| --- | --- |
| Name of child       | DoB       |

**Part B** **To be completed by the examining health professional and retained within the child’s health record**

|  |
| --- |
| Consent by the child with capacity to consent is essential. |
|  |  |
| Does the child have capacity to consent?  |  |
| 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). |
| **Signature** | **Date** |

|  |
| --- |
| List those present at assessment |
|       |

##### 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? |
|  |

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### Page 5

|  |  |
| --- | --- |
| Name of child       | DoB       |

|  |
| --- |
|  |
| 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 |       |       |       |

#### Immunisation status

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

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### Page 6

|  |  |
| --- | --- |
| Name of child       | DoB       |

1. 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 life style 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 |
|       |
| 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 |
|       |

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### Page 7

|  |  |
| --- | --- |
| Name of child       | DoB       |

|  |  |  |
| --- | --- | --- |
| Investigations | **Date** | **Result** |
| Thyroid function  |       |       |
| PKU |       |       |
| Haemoglobinopathy screen |       |       |
| Cystic fibrosis |       |       |
| Hepatitis B  |       |       |
| Hepatitis C |       |       |
| HIV |       |       |
| Genetic/chromosomes |       |       |
| Other |       |       |

#### 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       cm       centile Weight       kg       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? |
|       |
| **Cardiovascular system**      |
| Abdomen       |

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### Page 8

|  |  |
| --- | --- |
| Name of child       | DoB       |

|  |
| --- |
| Genitalia – (NB only where clinically indicated) |
|       |
| **Nervous system** (as clinically indicated) |
|       |
| Musculoskeletal system **(NB hip stability, scoliosis, etc)** |
|       |

1. Emotional and behavioural development (including carer’s report)

|  |
| --- |
|       |

1. Developmental/functional assessment

|  |  |
| --- | --- |
| Date        | Age       |
| Gross motor skills |
|       |
| Conclusion       |
| Fine motor skills and eye-hand co-ordination  |
|       |
| 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) |
|       |

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### Page 9

|  |  |
| --- | --- |
| Name of child       | DoB       |

|  |
| --- |
| 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/Co-ordinated support plan?  | Yes/No  |

##### Examining doctor

|  |  |
| --- | --- |
| Signature | Date |
|  |  |
| Name       | Address |
|       |
| Designation       |
| Qualifications       |
| Telephone       | Postcode       |
|  |  |
| Email       | Fax       |
|  |  |

**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.**

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### Page 10

|  |  |
| --- | --- |
| Name of child       | DoB       |

# Part C To be returned 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.

|  |
| --- |
| 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 |
|       |
| Developmental and educational history |
|       |
| Emotional and behavioural development  |
|       |
| Parenting issues in current placement |
|       |

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### Page 11

|  |  |
| --- | --- |
| Name of child       | DoB       |

|  |
| --- |
| HEALTH RECOMMENDATIONS FOR CHILD CARE PLAN |

|  |
| --- |
| Date of next health assessment |

|  |  |  |  |
| --- | --- | --- | --- |
| **Issues** | **Action required** | **By when** | **Named person responsible** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| 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       | Date       |
|  |  |
| Designation       | Address       |
|
| Qualifications       |
| Postcode       |
| Telephone       | Fax       |
|
| Email       |
|
|
| Signature | Panel |

##