

# Aboriginal and Torres Strait Islander health check – Adolescents and young people (12–24 years)

MBS items 715 VR/228 non-VR

## A good health check:

- is useful to the patient
- identifies health needs including patient health goals and priorities
- supports patients to take charge of their health and wellbeing
- provides a framework for primary and secondary disease prevention through healthcare advice, risk assessment and other measures
- is provided by the regular healthcare provider
- includes a plan for follow-up of identified health needs, priorities and goals.

**Disclaimer:** This is an example health check template that includes recommended core elements and is intended for use as a general guide only. Health checks should always be completed based on clinical judgement of what is relevant to individual patients and settings. Adaptation to local needs and priorities is encouraged, with reference to current Australian preventive health guidelines that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs, evidence-based and generally accepted in primary care practice, for example:

- [National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people](#), 3rd edition, The Royal Australian College of General Practitioners (RACGP) and National Aboriginal Community Controlled Health Organisation (NACCHO)
- [CARPA standard treatment manual](#), 7th edition, Central Australian Rural Practitioner's Association (CARPA).

Where an individual practitioner or service has skills and capacity to provide culturally safe healthcare, the range of elements in the health check, and use of clinical screening and assessment tools, may be extended.

## Key:

- Relevant to nKPIs
- Relevant to QI PIP

About the health check	Yes	No	N/A	
Eligible for health check (not claimed 715 or 228 in past nine months):				Date of last health check:
<b>Consent</b>				
Consent given after discussion of process and benefits of a health check:				
Parent/primary caregiver present for health check				Relationship to child:
Consent given for sharing of information with relevant healthcare providers:				Who/details:
Date:	Doctor:		Nurse:	
Aboriginal and/or Torres Strait Islander Health Worker / Health Practitioner:				
Location of health check:	<input type="checkbox"/> Clinic	<input type="checkbox"/> Home	<input type="checkbox"/> School	<input type="checkbox"/> Other:
<b>Patient details</b>				
Name:	Date of birth:		Age:	Gender:
Aboriginal and/or Torres Strait Islander status:	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Aboriginal and Torres Strait Islander	
Parents/primary carer/s:	<input type="checkbox"/> N/A	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Mother and father
Other family (details):			Other (details):	
Address:				

Home phone:		Mobile phone:		
Emergency contact:	Relationship to patient:		Emergency contact phone:	
Medicare number:	Reference number:		Expiry:	
Pension/Health Care Card number:				
	Yes	No	N/A	
Registered for Closing the Gap PBS Co-payment Measure (CTG):				
Registered for National Disability Insurance Scheme				Yes, number:
Do you have children?				Number of children:      Number of children in your care:
Are you responsible for caring for someone else?				Details:
Are name and contact details of other key providers (eg case workers, support services) up to date?				Details:

Assessment	Health priorities, actions and follow-up
<p><b>Current health/patient priorities</b></p> <p>What are the important things for you in this health check today? Details:</p> <p>Is there anything you are worried about? Details:</p> <p>Do you have any specific health goals? Is there anything in particular about your health and wellbeing that you would like to improve? Details:</p>	
<p><b>Medical history and current problems</b></p> <p> <input type="checkbox"/> Ear infections                      <input type="checkbox"/> Headaches or migraines  <input type="checkbox"/> Hearing problems                    <input type="checkbox"/> Diabetes  <input type="checkbox"/> Asthma                                    <input type="checkbox"/> Rheumatic heart disease  <input type="checkbox"/> High blood pressure                <input type="checkbox"/> Kidney disease  <input type="checkbox"/> Epilepsy                                 <input type="checkbox"/> Mental health                 </p> <p>Other relevant medical history, operations, hospital admissions, etc Details:</p>	

Assessment	Health priorities, actions and follow-up
<p><b>Regular medications: check if still required, appropriate dose, understanding of medication and adherence</b></p> <p>Do you take any regular medications (prescribed, over-the-counter, traditional, complementary and alternative)?</p> <p><input type="checkbox"/> None    <input type="checkbox"/> Yes, up to date in health record</p> <p><input type="checkbox"/> Understanding and adherence checked</p>	
<p><b>Allergies/adverse reactions</b></p> <p><input type="checkbox"/> Up to date in health record</p>	
<p><b>Relevant family history (including diabetes, heart disease, cancer, mental health)</b></p> <p>Details:</p>	
<p><b>Social and emotional wellbeing</b></p> <p>Social and emotional wellbeing assessment: consider tools such as Aboriginal and Torres Strait Islander Youth Social Emotional Wellbeing assessment question guide or HEEADSSS</p>	
<p><b>General</b></p> <p>Have there been any particular stressful life events that are impacting on you/your health lately?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    Details:</p>	
<p><b>Home and family</b></p> <p>Who do you live with?</p> <p>Details:</p> <p>Do you have stable housing?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    Details:</p> <p>Do you feel safe at home?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    Details:</p>	
<p><b>Learning and work</b></p> <p>Are you studying at school/uni?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    Details:</p> <p>Are you working?    <input type="checkbox"/> N/A    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Details (occupation including occupational hazards, disability, etc):</p>	

Assessment	Health priorities, actions and follow-up
<p><b>Mood</b></p> <p>How have you been feeling lately?</p> <p>Details:</p> <p>If indicated, ask about depression (consider screening tools, eg aPHQ-9, K5 or K10) and complete risk assessment</p> <p>Details:</p> <p>Explore other mental health concerns as indicated</p> <p>Details:</p>	
<p><b>Healthy eating, exercise, screen time and social connection</b></p> <p>Do you have any worries about your diet or weight?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Document conversation about age-appropriate healthy eating, which could include:</p> <ul style="list-style-type: none"> <li>• current diet including food and drinks</li> <li>• recommendations about fruit and vegetable intake, water as the main drink, avoiding sugary drinks, avoiding highly processed foods (including supermarket-bought and take-away like KFC, Maccas)</li> </ul> <p>Details:</p> <p>Are there any issues about availability of food?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Do you have any worries about physical activity or screen time?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Document conversation about age-appropriate recommendations re physical activity, exercise and screen time</p> <p>Details:</p> <p>Document conversation about social connection, which could include questions about sports/hobbies/clubs/other activities</p> <p>Details:</p>	
<p><b>Substance use, including tobacco</b></p> <p><b>Smoking (QI M2, PI 09, PI 10)</b></p> <p><input type="checkbox"/> Never smoked</p> <p><input type="checkbox"/> Ex-smoker <input type="checkbox"/> Quit &lt;12 months <input type="checkbox"/> Quit ≥12 months</p> <p><input type="checkbox"/> Current smoker How many? <input type="text"/> How long? <input type="text"/></p> <p><input type="checkbox"/> Wants to quit</p> <p><input type="checkbox"/> Other tobacco use</p> <p><input type="checkbox"/> Environmental exposure to tobacco smoke (home, car, etc)</p>	

Assessment	Health priorities, actions and follow-up
<p><b>Alcohol and other substance use (QI M2, PI 16)</b></p> <p>Quantity and frequency of:</p> <ul style="list-style-type: none"> <li>• alcohol</li> <li>• caffeine (coffee, soft drinks, iced coffee)</li> <li>• cannabis/yarndi/gunja</li> <li>• other substance use: IVDU, methamphetamine, other stimulants, opiates, solvents, other</li> </ul> <p><b>Details:</b></p>	
<p><b>Gambling</b></p> <p>Have you or someone close to you ever had issues with gambling?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p>	
<p><b>Sexual health (sexual activity, contraception, safe sex/protection, sexual orientation, gender identity, pressure to have sex, STIs)</b></p> <p>Is there anything that you are worried about in relation to puberty/your sexual health?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Consider discussing as relevant to age/sex/gender:</p> <ul style="list-style-type: none"> <li>• menstruation (including risk of anaemia)</li> <li>• current sexual activity</li> <li>• contraception</li> <li>• safe sex practice (eg use of condoms)</li> <li>• sexually transmitted infection symptoms and screening</li> <li>• blood-borne virus screening</li> </ul>	
<p><b>Immunisation (eligibility for funded vaccines may vary across jurisdictions)</b></p> <p><b>Check Australian Immunisation Register</b></p> <p>Immunisations up to date and recorded on Australian Immunisation Register (as per Australian Immunisation Handbook)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Immunisations due:</p> <p>Vaccines given today recorded on Australian Immunisation Register?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p>	
<p><b>Eye health</b></p> <p>Is there anything that you are worried about with your vision?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p><b>Eye examination</b></p> <p>Visual acuity R <input type="text"/> L <input type="text"/></p> <p>Details:</p>	

Assessment	Health priorities, actions and follow-up		
<p><b>Ear health and hearing</b></p> <p>Is there anything that you are worried about with your hearing?  <input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Last hearing test (audiology):</p> <p><b>Ear examination</b></p> <p>Otoscopy findings (may be more than one of these):</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p><b>Left ear</b></p> <p><input type="checkbox"/> Clear and intact</p> <p><input type="checkbox"/> Dull and intact</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Retracted</p> <p><input type="checkbox"/> Unable to view eardrum</p> <p><input type="checkbox"/> Wax</p> <p><input type="checkbox"/> Other:</p> </td> <td style="vertical-align: top;"> <p><b>Right ear</b></p> <p><input type="checkbox"/> Clear and intact</p> <p><input type="checkbox"/> Dull and intact</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Retracted</p> <p><input type="checkbox"/> Unable to view eardrum</p> <p><input type="checkbox"/> Wax</p> <p><input type="checkbox"/> Other:</p> </td> </tr> </table>	<p><b>Left ear</b></p> <p><input type="checkbox"/> Clear and intact</p> <p><input type="checkbox"/> Dull and intact</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Retracted</p> <p><input type="checkbox"/> Unable to view eardrum</p> <p><input type="checkbox"/> Wax</p> <p><input type="checkbox"/> Other:</p>	<p><b>Right ear</b></p> <p><input type="checkbox"/> Clear and intact</p> <p><input type="checkbox"/> Dull and intact</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Retracted</p> <p><input type="checkbox"/> Unable to view eardrum</p> <p><input type="checkbox"/> Wax</p> <p><input type="checkbox"/> Other:</p>	
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<p><b>Oral and dental health</b></p> <p>Is there anything that you are worried about with your teeth?  <input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Last dental checkup:</p> <p><b>Teeth and mouth check</b></p> <p>Examination findings:</p> <p>Document conversation about oral health and care of teeth</p> <p>Details:</p>			
<p><b>Skin</b></p> <p>Is there anything that you are worried about with your skin?  <input type="checkbox"/> Yes <input type="checkbox"/> No Details:</p> <p>Do you use sun protection?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Document conversation about sun protection as appropriate (ie sunscreen, hats, shade)</p> <p>Details:</p> <p><b>General skin examination</b></p> <p>Examination findings:</p>			
<p><b>Examination</b></p> <p>Height: <span style="margin-left: 150px;">Waist circumference (≥18 years):</span></p> <p>Weight (QI M3): <span style="margin-left: 100px;">Blood pressure:</span></p> <p>BMI: <span style="margin-left: 150px;">Heart rate and rhythm:</span></p>			

Assessment	Health priorities, actions and follow-up
<p><b>Investigations</b></p> <p><b>≥15 years (consider ≥12 years if indicated)</b></p> <p>Chlamydia, gonorrhoea: first void urine (male and female) <b>and/or</b> endocervical swab or self-administered vaginal swab (female) or throat and anal swab (men who have sex with men [MSM])</p> <p>Syphilis (endemic areas, MSM, others at high risk)</p> <p>Trichomoniasis: age ≤30 years, male and female, remote areas and other endemic areas, first void urine and/or endocervical swab or self-administered vaginal swab</p> <p>Blood-borne virus screening: <b>Age ≥18 years</b></p> <ul style="list-style-type: none"> <li>• HBV if status not known/not recorded on file</li> <li>• HCV, if risk factors</li> <li>• HIV, if risk factors</li> <li>• Full blood count</li> <li>• HbA1c or blood glucose level</li> <li>• Serum lipids</li> <li>• Kidney function including eGFR</li> <li>• Liver function tests</li> <li>• ACR</li> </ul>	

Finalising the health check				
<p><b>Patient priorities and goals:</b> What does the patient say are the important things that have come out of this health check?</p>				
<p><b>Brief intervention:</b> Advice and information provided during health check, for example:</p>				
<input type="checkbox"/> Healthy eating	<input type="checkbox"/> Screen use	<input type="checkbox"/> Physical activity and exercise	<input type="checkbox"/> Mental health and wellbeing	
<input type="checkbox"/> Safety/risky behaviours	<input type="checkbox"/> Smoking cessation	<input type="checkbox"/> Substance use/harm minimisation	<input type="checkbox"/> Safe sex/contraception	<input type="checkbox"/> Care of teeth and gums
<input type="checkbox"/> Other:				
<p><b>Care provided as part of the health check</b> (eg immunisations, medication review, investigations requested)</p>				
<p><b>Identified needs and plan</b> (including new diagnoses)</p>				
<p><b>Follow-up:</b> Consider what follow-up appointments can be made at the time of the health check</p>			<p><b>Reminder:</b> MBS follow up items for clients at risk of or with chronic disease are available to support follow-up of health checks</p>	
<p><b>Referrals and appointments, for example:</b></p> <p>Who</p>			<p>When</p>	
<input type="checkbox"/> GP follow-up				
<input type="checkbox"/> GP review of results of investigations				

<input type="checkbox"/> Aboriginal and/or Torres Strait Islander Health Worker follow-up	
<input type="checkbox"/> Aboriginal and/or Torres Strait Islander Health Practitioner follow-up	
<input type="checkbox"/> Practice nurse follow-up	
<input type="checkbox"/> Dentist	
<input type="checkbox"/> Paediatrician	
<input type="checkbox"/> Audiology	
<input type="checkbox"/> Speech pathology	
<input type="checkbox"/> Parenting programs/support services	
<input type="checkbox"/> Social and emotional wellbeing/mental health	
<input type="checkbox"/> Other:	
Recalls entered (eg clinical review including review of results, immunisations, asthma plan/cycle of care, investigations)	
Patient actions	
Patient has been offered a copy of this health check including details of follow-up and future appointments	
<input type="checkbox"/> Yes, copy taken	<input type="checkbox"/> Yes, but declined
<input type="checkbox"/> Not offered. Plan to follow up and offer at a later date	

**Health check claimed (PI 03)**

If you would like to provide feedback on this template, please contact [aboriginalhealth@racgp.org.au](mailto:aboriginalhealth@racgp.org.au)

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*We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.*

