

**Medicare Health Assessment for
Aboriginal and Torres Strait Islander People**

Adult Health Assessment (15-54)

GUMS AND DENTITION: Normal Abnormal

IDENTIFIED ISSUES	ACTION

EAR AND HEARING: Otoscopy Whisper test (if indicated)

IDENTIFIED ISSUES	ACTION

VISION: Test near and distance visual acuity

IDENTIFIED ISSUES	ACTION

URINALYSIS

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL EXAMINATION – AS INDICATED FOR PATIENT

TRICHIASIS (Note: Examine those people who have grown up in remote communities or have a history of 'sore or watery eye')

IDENTIFIED ISSUES	ACTION

SKIN

IDENTIFIED ISSUES	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED ISSUES	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS (eg referral details)
Fasting blood sugar	<input type="checkbox"/>	Date: __/__/____	
Lipids	<input type="checkbox"/>	Date: __/__/____	
Pap Smear	<input type="checkbox"/>	Date: __/__/____	
STI	<input type="checkbox"/>	Date: __/__/____	
Mammography	<input type="checkbox"/>	Date: __/__/____	
Optometry	<input type="checkbox"/>	Date: __/__/____	
Other:.....			

ASSESSMENT OF PATIENT

(based on consideration of evidence from patient history, examination and results of any investigation)

EXISTING HEALTH ISSUES	IDENTIFIED RISK FACTORS

INTERVENTION ACTION

HEALTH ADVICE PROVIDED TO PATIENT

.....

OTHER ACTION (if any)

.....



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Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed in the Explanatory Notes for the health assessment found at www.health.gov.au/mbsonline. The first page of this form can be used as a report of the health assessment.

Patient's Name Male Female DOB: __/__/____ or Age: ____

Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander

Work status.....

Current contact details

Address.....

Phone.....

Alternative contact details.....

Address.....

Phone.....

Patient Consent

Explanation of health assessment given Yes

Patient consent for health assessment given Yes

Date consent was given: __/__/____

Consent given for information to be collected by

Aboriginal health worker

Practice nurse

Other suitably qualified health professional

Previous health assessment

Has the patient had a previous health assessment?

No Yes

Date of last health assessment (if known) __/__/____

Service provided by DR.....

PATIENT'S OVERALL HEALTH

.....

RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT

.....

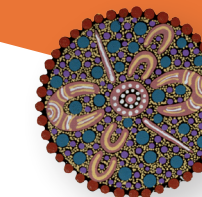
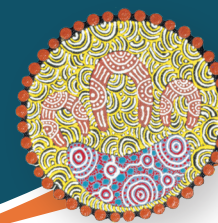
TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

TEST	AVAILABLE RESULTS & WHAT THEY MEAN

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STRATEGY FOR GOOD HEALTH: REQUIRED TREATMENT/SERVICES/HEALTH ADVICE

TREATMENT	HEALTH ADVICE	HEALTH SERVICES NEEDED

ACTION TO BE TAKEN BY PATIENT

.....

Next appointment with doctor:..... Date: ___/___/___ Next Health Assessment: ___/___/___

GP: Dr GP's Signature: Date: ___/___/___

MEDICAL HISTORY

FAMILY RELATIONSHIP

Does the patient care for someone else? No Yes

Is the patient cared for by someone else? No Yes

CURRENT ISSUES	CURRENT RISK FACTORS

ALLERGIES/DRUG INTOLERANCE

.....

CURRENT MEDICATIONS (including prescription and over the counter and supplied by doctor without prescription)

.....

RELEVANT FAMILY MEDICAL HISTORY

.....

IMMUNISATION STATUS (referring to current age/sex schedule)

TYPE	DATE	TYPE	DATE

PHYSICAL ACTIVITY

IDENTIFIED ISSUES	ACTION

NUTRITION

IDENTIFIED ISSUES	ACTION

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

IDENTIFIED ISSUES	ACTION

HEARING LOSS

IDENTIFIED ISSUES	ACTION

MOOD (depression and self harm risk)

IDENTIFIED ISSUES	ACTION

SEXUAL AND REPRODUCTIVE HEALTH

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL HISTORY AS INDICATED FOR PATIENT

VISUAL ACUITY (ask about clarity and comfort of vision at distance and near, recommended for over 40s)

IDENTIFIED ISSUES	ACTION

ENVIRONMENTAL AND LIVING CONDITIONS

IDENTIFIED ISSUES	ACTION

Other history considered necessary by doctor or collector (eg work environment)

IDENTIFIED ISSUES	ACTION

MEDICAL EXAMINATION

BLOOD PRESSURE:..... PULSE RATE AND RHYTHM: Normal Abnormal

IDENTIFIED ISSUES	ACTION

WEIGHT:..... Height: BMI:..... Waist circumference (if indicated):

IDENTIFIED ISSUES	ACTION