Information Governance

Chris West
Executive Director
Council House
Earl Street
Coventry
CV1 5RR

Please contact Information Governance
Direct line 024 7683 3323
infogov@coventry.gov.uk

Dear Sir/Madam

Freedom of Information Act 2000 (FOI) Request ID: REQ00446

Thank you for your request:

'I am doing an audit of the health assessment forms used with looked after children and young people in order to develop a quality rating tool. I just wondered whether your authority pay to use the BAAF forms or whether you have developed your own. If you have developed your own, please could you send me a blank copy. If you use the BAAF forms then please also let me know for information relating to health assessment forms.'

In response to your request, the local authority uses BAAF forms to conduct initial health assessments for children and young people in care.

As requested, enclosed are the following review health assessments forms which have been developed.

- Review Health Assessments for 0-9 years.
- Review Health Assessments for 10 years and over

The supply of information in response to a freedom of information request does not confer an automatic right to re-use the information. You can use any information supplied for the purposes of private study and non-commercial research without requiring further permission. Similarly, information supplied can also be re-used for the purposes of news reporting. An exception to this is photographs. Please contact us if you wish to use the information for any other purpose.

Should you wish to make any further requests for information, you may find what you are looking for is already published on the Council's web site and in particular its FOI/EIR Disclosure log, Council's Publication Scheme, Open Data and Facts about Coventry.

If you are unhappy with the handling of your request, you can ask us to review our response. Requests for reviews should be submitted within 40 days of the date of receipt of our response to your original request – email: infogov@coventry.gov.uk

If you are unhappy with the outcome of our review, you can write to the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or email casework@ico.org.uk.

Please remember to quote the reference number above in your response.

Yours faithfully

Information Governance Assistant

Enclosures: 'REQ00446 LAC RHA 10+ years 2015'
'REQ00446 LAC RHA 0-9 years 2015'

CONFIDENTIAL

LOOKED AFTER CHILDRENS REVIEW HEALTH ASSESSMENT FORM FOR YOUNG PEOPLE AGED FROM BIRTH TO 9 YEARS.

Name: **D.O.B:** **NHS No:**

Details of Health Professional completing Review Health Assessment

Name: Signature:

Date: Email:

Telephone No: Date Statutory Health Assessment undertaken:

Venue Health Assessment undertaken:

Personal Child Health Record Available (Red/Blue)? Yes ☐ No ☐

Who is present at the Assessment?

Name: .... Relationship to Child: ....

Name: .... Relationship to Child: ....

Details of Health Visitor / School Nurse / Family Nurse / Special School Nurse:

Name:... Phone No:..

Nursery / School:…………………………………

Previous Health Plan - Date of previous Health Assessment? ....

Outstanding health needs form previous health plan? Yes ☐ No ☐
If yes please state below:

1.
2.
3.
4.
5.

Name: **D.O.B:** **NHS No:**

Any changes since last health assessment? Yes ☐ No ☐

Other Professional involved with the child:

Name	Role	Reason for involvement	Contact details

Allergies.

Any known allergies? Yes ☐ No ☐

Details:

Immunisation Status (**Please ensure that a review of the immunisations is printed from Mckesson or obtained from the GP to ensure vaccination status**).

Any contraindications to immunisations? Yes ☐ No ☐

Any vaccinations since the last health assessment? Yes ☐ No ☐

Specify:

Is the Young Person fully immunised for their age? Yes ☐ No ☐

Please record all required immunisations on the health care plan.

Past medical history (**see previous LAC HA's**)

Name: **D.O.B:** **NHS No:**

Has the child been diagnosed as having any on-going health conditions or previously diagnosed health condition which has now resolved? Yes ☐ No ☐

Details:

ACCIDENT AND EMERGENCY, HOSPITAL ADMISSIONS, OUT-PATIENTS and/or THERAPY APPOINTMENTS (since the last health assessment)

Date	Specialty	Place	Reason for Attendance

Current medical needs.

Medication/Treatment/Therapy.

Name: **D.O.B:** **NHS No:**

Is the child scheduled to attend any health or therapy appointments in the future? Yes ☐ No ☐

Date	Specialty	Place	Reason for Attendance

Developmental information.

Is the child up to date with their developmental assessments? Yes ☐ No ☐
Are developmental or learning needs being met? Yes ☐ No ☐
Details:

Has the child been diagnosed as having any disability or developmental delay, e.g. Assessment/Schedule of Growing skills? Yes ☐ No ☐

Details:

Gross motor skills:

Fine motor skills:

Speech and Language:

Cognitive skills:

Self-care:

Social:

Continence.

Is the child toilet trained? . Yes ☐ No ☐

Are there any daytime wetting problems? Yes ☐ No ☐

If yes, what kind of problems?

Frequency (more than 7 voids per day?) Yes ☐ No ☐

Urgency (sudden desire to void) Yes ☐ No ☐

Wetting Yes ☐ No ☐

How often per week?

Are there any night time wetting problems? Yes ☐ No ☐

If yes, what was the age of onset? ....

Number of wet nights per week? ....

Number of incidences per night? …………..

Any soiling problems? . Yes ☐ No ☐

Details:

Any indication of constipation? Yes ☐ No ☐

Details:

(If constipation is indicated please use the constipation assessment tool)

Physical Health.

HEALTH DEVELOPMENT (Plot onto Centile chart in child's records).

Weight: .... Percentile: ....

Height: .... Percentile: ....

Head circumference……………………… Percentile: ………………

Age: .... BMI: …………... (www.nhs.uk healthy weight calculator)

(If greater than 2 percentiles)

....

Physical Examination Required/Completed: Yes ☐ No ☐

(Please complete physical examination details below)

Name: **D.O.B:** **NHS No:**

Physical Examination details:

Demeanour / General appearance

Head circumference

Skin

Chest

Cardio Vascular System

Abdo

CNS

MS

ENT

Vision/Squint/Red Reflex

Name: **D.O.B:** **NHS No:**

Education.

Any educational assessments since the last health assessment? Yes ☐ No ☐

Specify:

Does the child receive additional help in school? Yes ☐ No ☐

Does the child have an Education and Health Care Plan (EHP) Yes ☐ No ☐

Date of last Personal Educational Plan (PEP) meeting……………..

Outstanding interventions Yes ☐ No☐

(eg. Statutory Educational Assessment, Medical assessments)

Details:

Healthy living / Health Promotion.

DIETARY NEEDS

Health Eating Check List

Food Groups	Food	Every Day	Most Days	Sometimes	Not at all
Fruit and Vegetables	Fruit - including fruit juice				
	Vegetables and Salad				
Carbohydrates	Rice and pasta - including spaghetti, macaroni, etc				
	Breads				
	Potatoes, including chips				
	Cereals and grains - including breakfast cereals, couscous				
Proteins	Meat				
	Fish				
	Eggs				
	Cheese				
	Pulses - baked beans, lentils				
Snacks	Crisps				
	Biscuits				
	Sweets				
Drinks	Fizzy drinks				
	Water				
	Milk and milk products				

Other dietary/feeding requirements? Yes ☐ No ☐

Details:

Does the child receive a healthy and varied diet? Yes ☐ No☐

Advice given:

Name: **D.O.B:** **NHS No:**

Dental Care.

Are teeth brushed twice a day with fluoride toothpaste? Yes ☐ No ☐
Regularly attending dentist? Yes ☐ No ☐
Phobic dental referral required Yes ☐ No ☐
Name and location of Dentist:

Date of Last Dental Appointment and Treatment Outcome?

Does a referral need to be made for dental registration by the carer Yes ☐ No ☐

Hearing.

Any concerns about hearing? Yes ☐ No ☐
Details and Action taken:

Vision.

Is the child registered with an optician? Yes ☐ No ☐
Are there any concerns regarding their vision? Yes ☐ No ☐
Details:

Name and location of Optician:

Date of last appointment and outcome?

Does a referral need to be made for optician registration by carer? Yes ☐ No ☐

Environment.

Does anyone in the household smoke? Yes ☐ No ☐
Do carers/parents have appropriate safety equipment in the home and for travelling?
(Car seats are required for all children under 135cm or 12 years of age) Yes ☐ No ☐
Are there suitable toys for the child's age and development at the home? Yes ☐ No ☐
Comments:

Name: **D.O.B:** **NHS No:**

Smoking. (Tick if Not applicable ☐)

Do you smoke? Yes ☐ No ☐
How many cigarettes per week day: Weekends:
How old were you when you started smoking?
Have you been given information about how smoking affects your health and access to smoking cessation support services? Yes ☐ No ☐
Would you like help to stop smoking? Yes ☐ No ☐

Advice given:

Physical Activity.

Children and young people should exercise at least 5 hours per week (Incl. PE sessions).
Do you do this? Most of the time ☐ or Yes ☐ No ☐

How would you like to increase your physical activity? (To be raised in health care plan for action by Social Worker)

PUBERTY AND RELATIONSHIPS.

Have you been given information about how your body changes as you grow up? Yes ☐ No ☐

If female:

Have you started your periods? Yes ☐ No ☐

Emotional and Behavioural Development. (If appropriate)

CONTACT WITH FAMILY AND SIBLINGS

Contact with	Frequency	Effect on Child

Is the child settled in placement? Yes ☐ No ☐

Does the child sleep well? Yes ☐ No ☐

Is the child sociable and talkative? Yes ☐ No ☐

Does the child talk about their feelings? Yes ☐ No ☐

Is anybody helping the child collate a life story book or keeping photographs/ mementoes?

Yes ☐ No ☐

Can the child (if age appropriate) say who their closest friends are and how long they have been friends?

What does the young person like doing or what is he/she really good at?

Is the child experiencing any emotional health or behavioural difficulties? Yes ☐ No ☐

Details:

Has the child ever been bullied? Yes ☐ No ☐

Has the child lived in a household with domestic violence? Yes ☐ No ☐

Are there any attachment difficulties? Yes ☐ No ☐

Does the child say they are or present as happy? Yes ☐ No ☐ Sometimes ☐

Does the child say they are or appear to be sad? Yes ☐ No ☐ Sometimes ☐

Does the child lose their temper or get violent? Yes ☐ No ☐ Sometimes ☐

Does the Carer have any other concerns about the child's health or well-being? Yes ☐ No ☐

Details:

Name: **D.O.B:** **NHS No:**

Have any other professionals/carers expressed concerns? Yes ☐ No ☐

Details:

Any other health promotion issues discussed with child/parent/carer or any other area of health concern? Yes ☐ No ☐

Child's feeling and views (please record in the child's words any significant comments or statements made during the assessment. Please ensure you see the child alone)

"What's your favourite thing?"

"Three wishes"

Other comments made by child

Please return Forms B and C to the LAC Health Team via LAC Health Co-ordinator, 1st Floor Paybody Building. C/O City Centre Coventry Health centre, 2 Stoney Stanton Road, Coventry CV1 4FS or secure email to CWP-TR.Lookedafterchildren@nhs.net

Or if out of area : Please return Forms B and C to Safeguarding Co-ordinator/LAC Out of City Co-ordinator, Coventry and Rugby CCG, 2nd Floor, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ

Email: CRCCG.Safeguarding@nhs.net

COVENTRY AND WARWICKSHIRE PARTNERSHIP TRUST

LOOKED AFTER CHILDRENS REVIEW HEALTH ASSESSMENT FOR BIRTH TO 9 YEARS (PART C)

SUMMARY REPORT AND HEALTH CARE PLAN

Name: **D.O.B:**
NHS no:
Social Worker:
Nursery/School:
Date of Assessment:
Venue:

Summary of health needs

Past medical History

Current Health Needs

Unmet health Needs

NEW HEALTH CARE PLAN

Issues	Action Required	By When	Named Person Responsible
Permanently Registered with GP? Yes ☐ No ☐ **GP Name/Address** If you wish to change your GP, visit the GP surgery you want to join and ask them to register you as a patient. For more information and to find your nearest GP surgery visit **www.nhs.uk**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Known Allergies? Yes ☐ No ☐			
Immunisations up to date (if known)? Yes ☐ No ☐ Dates of immunisations since last assessment For more information visit **www.nhs.uk/conditions/**vaccinations			
Regular attendance at Dentist? Yes ☐ No ☐ Date of last appointment: **Dentist name and address** If you would like to change dental surgery visit **www.nhs.uk** for information on local NHS dental practices or call **NHS 111**.			
Regular attendance at Opticians? Yes ☐ No ☐ Date of last appointment **Optician name and address** To find an optician near you visit **www.nhs.uk**			
Diet More information can be obtained from **www.nhs.uk/change4life**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Growth **Weight: Centile:** **Height: Centile:** **OFC: Centile:**			
Exercise More information can be found at **www.nhs.uk/livewell** or **www.nhs.uk/change4life**			
Medical needs (including enuresis). Yes ☐ No ☐ For additional advice regarding potty training, wetting, soiling and constipation visit **www.eric.org.uk**			
Developmental needs Yes ☐ No ☐			
Behaviour / Emotional/Attachment Needs For more information regarding mental health and the support available in your area visit **www.mind.org.uk.**			
Relationships/Puberty For more information visit **www.besavvy.org.uk**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Risk Taking behaviours Yes ☐ No ☐ Visit **www.compass-uk.org** for more information about overcoming drug and alcohol problems.			
Health risk due to smoking Yes ☐ No ☐ Smoker ☐ Secondary ☐ Support from smoking cessation services can be accessed by calling free on: **0300 200 0011** or **Text QUIT to 07768 867987** Or Email: **smokefree.coventry@covwarkpt.nhs.uk**			

Date of review of health care plan and health outcomes by the Social Worker : …………… (within 3 months of Health assessment)

HEALTH PROFESSIONAL COMPLETING PART C

Name:
Designation:
Date:
Postal Address: SEE BELOW
Email:
Phone:
Signature: ....
Date next Health Assessment due: 6 months ☐ ....
12 months☐ ……………………………………

Name: **D.O.B:** **NHS No:**

Please return Forms B and C to the LAC Health Team via LAC Health Co-ordinator, 1st Floor Paybody Building, City of Coventry Health Centre, Coventry, CV1 4FS or secure email CWP-TR.Lookedafterchildren@nhs.net . These will then be forwarded to LAC Co-ordinator Social Care via secure email lachealthforms@coventry.gcsx.gov.uk

Or if out of area : Please return Forms B and C to Safeguarding Co-ordinator/LAC Out of City Co-ordinator, Coventry and Rugby CCG, 2nd Floor, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ

Email: CRCCG.Safeguarding@nhs.net

OFFICE USE

Copy of plan sent by health to (Tick)	**Copy of plan sent by Social Care to**
☐ Social care ☐GP☐SN/HV	☐Social worker ☐IRO
Date:	

CONFIDENTIAL

LOOKED AFTER CHILDRENS REVIEW HEALTH ASSESSMENT FORM FOR YOUNG PEOPLE AGED 10 YEARS AND OVER

Name: **D.O.B:** **NHS No:**

Details of Health Professional completing Review Health Assessment

Name: Signature:

Date: Email:

Telephone No: Date Statutory Health Assessment undertaken:

Venue Health Assessment undertaken:

Personal Child Health Record Available (Red/Blue)? Yes ☐ No ☐

Who is present at the Assessment?

Name: .... Relationship to Child: ....

Name: .... Relationship to Child: ....

Details of School Nurse / Family Nurse / Special School Nurse:

Name: Phone No:

School/ College:

Previous Health Plan - Date of previous Health Assessment? ....

Outstanding health needs form previous health plan Yes ☐ No ☐
If yes please state below:

1.
2.
3.
4.
5.

Name: **D.O.B:** **NHS No:**

Any changes since last health assessment? Yes ☐ No ☐

Other Professional involved with the child:

Name	Role	Reason for involvement	Contact details

Allergies.

Any known allergies? Yes ☐ No ☐

Details:

Immunisation Status (Please ensure that a review of the immunisations is printed from Pint from Mckesson or obtained from GP to ensure vaccination status)

Any contraindications to immunisations? Yes ☐ No ☐

Any vaccinations since the last health assessment? Yes ☐ No ☐

Specify:

Is the Young Person fully immunised for their age? Yes ☐ No ☐

Please record all required immunisations on the health care plan.

Past medical history (see previous LAC HA's)

Name: **D.O.B:** **NHS No:**

Has the child been diagnosed as having any on-going health conditions or previously diagnosed health condition which has now resolved? Yes ☐ No ☐

Details:

ACCIDENT AND EMERGENCY, HOSPITAL ADMISSIONS, OUT-PATIENTS and/or THERAPY APPOINTMENTS (since last health assessment)

Date	Specialty	Place	Reason for Attendance

Current medical needs

Medication/Treatment/Therapy

Is the child scheduled to attend any health or therapy appointments in the future? Yes ☐ No ☐

Date	Specialty	Place	Reason for Attendance

Developmental information.

Are developmental or learning needs being met? Yes ☐ No ☐

Details:

Has the child been diagnosed as having any disability or developmental delay, e.g. Assessment/Schedule of Growing skills? Yes ☐ No ☐

Details:

Gross motor skills:

Fine motor skills:

Speech and Language:

Cognitive skills:

Self-care:

Social:

Name: **D.O.B:** **NHS No:**

Continence.

Is the child toilet trained? . Yes ☐ No ☐

Are there any daytime wetting problems? Yes ☐ No ☐
If yes, what kind of problems?
Frequency (more than 7 voids per day?) Yes ☐ No ☐
Urgency (sudden desire to void) Yes ☐ No ☐
Wetting Yes ☐ No ☐
How often per week?

Are there any night time wetting problems? Yes ☐ No ☐
If yes, what was the age of onset? ....
Number of wet nights per week? ....
Number of incidences per night? …………..

Any soiling problems? . Yes ☐ No ☐
Details:

Any indication of constipation? Yes ☐ No ☐
Details:

(If constipation is indicated please use the constipation assessment tool)

Physical Health.

HEALTH DEVELOPMENT (Plot onto Centile chart in child's records)

Weight: .... Percentile: ....
Height: .... Percentile: ....
Head circumference…………………………Percentile:…………………
Age: .... BMI: ..(www.nhschoices)
(If greater than 2 percentiles)

Physical Examination Required/Completed: Yes ☐ No ☐
(Please complete physical examination details below)

Name: **D.O.B:** **NHS No:**

Physical Examination details:

Demeanor/General appearance

Head circumference

Skin

Chest

Cardio Vascular System

CNS

Abdo

MS

ENT

Vision/Squint/Red Reflex

Name: **D.O.B:** **NHS No:**

Education.

Any assessments since the last health assessment? Yes ☐ No☐

Specify:

Does the child receive additional help in school? Yes ☐ No ☐

Does the child have an Education and Health Care Plan (EHP) Yes ☐ No ☐

Date of last Personal Educational Plan (PEP) meeting……………..

Outstanding interventions Yes ☐ No☐

(eg. Statutory Educational Assessment, Medical assessments)

Details:

Future plans regarding education and/or work.

What do you want to do after leaving school/college?

Details:

Healthy living/Health Promotion.

DIETARY NEEDS

Health Eating Check List

Food Groups	Food	Every Day	Most Days	Sometimes	Not at all
Fruit and Vegetables	Fruit - including fruit juice				
	Vegetables and Salad				
Carbohydrates	Rice and pasta - including spaghetti, macaroni, etc				
	Breads				
	Potatoes, including chips				
	Cereals and grains - including breakfast cereals, couscous				
Proteins	Meat				
	Fish				
	Eggs				
	Cheese				
	Pulses - baked beans, lentils				
Snacks	Crisps				
	Biscuits				
	Sweets				
Drinks	Fizzy drinks				
	Water				
	Milk and milk products				

Other feeding requirements? Yes ☐ No ☐

Details:

Does the child receive a healthy and varied diet? Yes ☐ No ☐

Does your Carer think your diet is healthy? Yes ☐ No ☐

Advice given:

Name: **D.O.B:** **NHS No:**

Dental Care.

Are teeth brushed twice a day with fluoride toothpaste? Yes ☐ No ☐
Regularly attending dentist? Yes ☐ No ☐
Phobic dental referral required Yes ☐ No ☐
Name and location of Dentist:

Date of Last Dental Appointment and Treatment Outcome?

Does referral need to be made for dental registration by carer Yes ☐ No ☐

Hearing.

Any concerns about hearing? Yes ☐ No ☐
Details and Action taken:

Vision.

Is the child registered with an optician? Yes ☐ No ☐
Are there any concerns regarding their vision? Yes ☐ No ☐
Details:

Name and location of Optician:
Date of last appointment and outcome?

Does referral need to be made for optician registration by carer? Yes ☐ No ☐

Environment.

Does anyone in the household smoke? Yes ☐ No ☐
Do carers/parents have appropriate safety equipment in the home and for travelling?
(Car seats are required for all children under 135cm or 12 years of age) Yes ☐ No ☐

Smoking.

Do you smoke? Yes ☐ No ☐
How many cigarettes per week day: Weekends:
How old were you when you started smoking?
Have you been given information about how smoking affects your health and access to smoking cessation support services? Yes ☐ No ☐
Would you like help to stop smoking? Yes ☐ No ☐

Advice given:

Name: **D.O.B:** **NHS No:**

Alcohol.

Do you drink alcohol? Yes ☐ No ☐

How much per week?

Do you drink alcohol before lunch time? Yes ☐ No ☐

Do you binge drink? Yes ☐ No ☐

Have you been given information on how alcohol affects your health and access to alcohol support services? Yes ☐ No ☐

Would you like to talk about anything else concerning alcohol? Yes ☐ No ☐

Advice given:

Alcohol screening tool used (EIS form) Yes ☐ No ☐

Referral to alcohol agency required? eg. Compass Yes ☐ No ☐

Advice given:

Substance Misuse.

Have you used drugs or other substances (i.e. solvents, aerosols?) Yes ☐ No ☐

If yes, what types of drugs and how often?

Type of drug/substance	How often used

Have you been given information about how drugs affect your health and access to substance use support services? Yes ☐ No☐

Would you like the opportunity for any support and advice about drugs? Yes ☐ No ☐

Screening tool completed (EIS form) Yes ☐ No ☐

Referral to drugs agency required? eg. Compass Yes ☐ No ☐

Advice given:

Physical Activity.

Children and young people should exercise at least 5 hours per week (Incl. PE sessions).
Do you do this? Most of the time ☐ or Yes ☐ No ☐

How would you like to increase your physical activity? (To be raised in health care plan for action by Social Worker)

Puberty, Relationships, Sexual Health and Contraception.

Have you been given information about how your body changes as you grow up? Yes ☐ No ☐

If female:
Have you started your periods? Yes ☐ No ☐
Have you got any concerns with your menstrual cycle? Yes ☐ No ☐

Are you sexually active? Yes ☐ No ☐
Are you using contraception? Yes ☐ No ☐
Details:

Contraceptive advice given:

Does the young person have an awareness of accessing:

- Contraception and Sexual Health Clinic Yes ☐ No ☐
- GUM Clinic Yes ☐ No ☐
- Emergency Contraception Yes ☐ No ☐
- Pharmacy services Yes ☐ No ☐

Advice:

Is the young person at risk or being sexually exploited (CSE)? Yes ☐ No ☐
If there are concerns, please use Coventry LCSB CSE screening tool.

Are you happy for this information to be recorded and shared on your health care plan Yes ☐ No ☐

This must be completed if discussing sexual health with young people under the age of 16 years.

FRASER COMPETENCY STATEMENT

I [Health Professional] am satisfied that:-

- He/she could not be persuaded to tell his/her parents themselves or permit a health professional to do so.
- He/she understands the advice
- In the case of sexual matters, he/she is likely to begin or continue having sexual intercourse with or without contraceptive treatment of treatment for a sexually transmitted infection
- Unless he/she receives advice or treatment his/her physical or mental health or both are likely to suffer
- His/her best interests require the advice, treatment or both without parental consent.

And I have determined that he/she is Fraser competent to consent to this episode of advice, treatment or intervention.

Signature Print Name
Designation Date.

The above issue has been discussed with me……………………………………(**Signed by young person**)

The Fraser competency test is to be found in the judgement of Lord Frazer in the case of Gillick V West Norfolk and Wisbech Area Health Authority and another [1985] 3 All ER 402. Silber J reiterated and slightly expanded Lord Fraser's guidelines in the case of R (on the application of Axon) V Secretary of State For Health [2006] EWHC 37 (Admin).

Emotional and Behavioural Development.

CONTACT WITH FAMILY AND SIBLINGS

Contact with	Frequency	Effect on Child

Is the child settled in placement? Yes ☐ No ☐

Is the child sociable and talkative? Yes ☐ No ☐

Does the child talk about their feelings? Yes ☐ No ☐

How do you get on with the people you live with?

Is anybody helping you make a life story book or keeping photographs/ Mementoes? Yes ☐ No ☐

Can the child say who their closest friends are and how long they have been friends?

What does the young person like doing or what is he/she really good at?

Is the child experiencing any emotional health or behavioural difficulties? Yes ☐ No ☐

Details:

Do you have a trusted adult to talk to? Yes ☐ No ☐

Do you find it easy to talk to and get on with different people? Yes ☐ No ☐

Does the Carer have any concerns about the child's health or well-being? Yes ☐ No ☐

Has the child ever been bullied? Yes ☐ No ☐

Has the child lived in a household with domestic violence? Yes ☐ No ☐

Are there any attachment difficulties? Yes ☐ No ☐

Do you consider yourself to be happy? Yes ☐ No ☐ Sometimes ☐

Do you ever get worried or sad? Yes ☐ No ☐ Sometimes ☐

Do you lose your temper or get violent? Yes ☐ No ☐ Sometimes ☐

Do you sleep well? Yes ☐ No ☐

Have you ever deliberately harmed yourself? Yes ☐ No ☐
(by scratching, cutting or taking an overdose)

Have you or currently suffer from any emotional health issues (eg. eating disorder, Obsessive compulsive disorder, anxiety, depression, phobias) Yes ☐ No ☐

Details:

Other behavioural problems, specify (ADHD problems/self-discipline and boundaries)

Details:

Have you seen a mental health professional in the past? Yes ☐ No ☐

Are you seeing a mental health professional now? Yes ☐ No ☐

Advice given regarding the emotional health issues raised:

Are you involved with the Youth Offending Service Yes ☐ No ☐

Details:

Have any other professionals/carers expressed concerns? Yes ☐ No ☐

Details:

Any other health promotion issues discussed with child/parent/carer or any other area of health concern? Yes ☐ No ☐

Child's feelings and views (please record in the child's words any significant comments or statements made during assessment. Please ensure you see the child alone).

"What's your favourite thing?"

Name: **D.O.B:** **NHS No:**

"Three wishes"

Other comments made by child/young person

Would you like to receive a copy of your Health Care Plan? Yes ☐ No ☐

Please return Forms B and C to the LAC Health Team via LAC Health Co-ordinator, 1st Floor Paybody Building. C/O City Centre Coventry Health centre, 2 Stoney Stanton Road, Coventry CV1 4FS or secure email to CWP-TR.Lookedafterchildren@nhs.net

Or if out of area : Please return Forms B and C to Safeguarding Co-ordinator/LAC Out of City Co-ordinator, Coventry and Rugby CCG, 2nd Floor, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ

Email: CRCCG.Safeguarding@nhs.net

COVENTRY AND WARWICKSHIRE PARTNERSHIP TRUST

LOOKED AFTER CHILDREN REVIEW HEALTH ASSESSMENT FOR 10-18 YEARS (PART C)

SUMMARY REPORT AND HEALTH CARE PLAN

Name: **D.O.B:**
NHS no:
Social Worker:
School/ College / Employment:
Date of Review Assessment:
Venue:

Summary of health needs

Past medical History

Current Health Needs

Unmet health Needs

NEW HEALTH CARE PLAN

Issues	Action Required	By When	Named Person Responsible
Permanently Registered with GP? Yes ☐ No ☐ **GP Name/Address** If you wish to change your GP, visit the GP surgery you want to join and ask them to register you as a patient. For more information and to find your nearest GP surgery visit **www.nhs.uk**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Known Allergies? Yes ☐ No ☐			
Immunisations up to date (if known)? Yes ☐ No ☐ Dates of immunisations since last assessment For more information visit **www.nhs.uk/conditions/**vaccinations			
Regular attendance at Dentist? Yes ☐ No ☐ Date of last appointment: **Dentist name and address** If you would like to change dental surgery visit **www.nhs.uk** for information on local NHS dental practices or call **NHS 111**.			
Regular attendance at Opticians? Yes ☐ No ☐ Date of last appointment **Optician name and address** To find an optician near you visit **www.nhs.uk**			
Diet More information can be obtained from **www.nhs.uk/change4life**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Growth **Height: Centile:** **Weight: Centile:**			
Exercise More information can be found at **www.nhs.uk/livewell** or **www.nhs.uk/change4life**			
Medical needs (including enuresis). Yes ☐ No ☐ For additional advice regarding potty training, wetting, soiling and constipation visit **www.eric.org.uk**			
Developmental needs Yes ☐ No ☐			
Behaviour / Emotional/Attachment Needs For more information regarding mental health and the support available in your area visit **www.mind.org.uk.**			
Relationships/Puberty For more information visit **www.besavvy.org.uk**			

Name: **D.O.B:** **NHS No:**

Issues	Action Required	By When	Named Person Responsible
Risk Taking behaviours Yes ☐ No ☐ **Drug / Substance misuse** Yes ☐ No ☐ Visit **www.compass-uk.org** for more information about overcoming drug and alcohol problems. **Sexual exploitation** Yes ☐ No ☐ **Offending behaviour** Yes ☐ No ☐			
Health risk due to smoking Yes ☐ No ☐ Smoker ☐ Secondary ☐ Support from smoking cessation services can be accessed by calling free on**: 0300 200 0011** or **Text QUIT to 07768 867987** Or Email: **smokefree.coventry@covwarkpt.nhs.uk**			

Date of review of health care plan and health outcomes by the Social Worker : …………… (within 3 months of Health assessment)

HEALTH PROFESSIONAL COMPLETING PART C

Name:
Designation:
Date:
Postal Address: SEE BELOW
Email:
Phone:
Signature: ……………………………………………………………….
Date next Health Assessment due: 12 months☐ ……………………………………

Name: **D.O.B:** **NHS No:**

Please return Forms B and C to the LAC Health Team via LAC Health Co-ordinator, 1st Floor Paybody Building, City of Coventry Health Centre, Coventry, CV1 4FS or secure email CWP-TR.Lookedafterchildren@nhs.net . These will then be forwarded to LAC Co-ordinator Social Care via secure email lachealthforms@coventry.gcsx.gov.uk

Or if out of area : Please return Forms B and C to Safeguarding Co-ordinator/LAC Out of City Co-ordinator, Coventry and Rugby CCG, 2nd Floor, Christchurch House, Greyfriars Lane, Coventry CV1 2GQ

Email: CRCCG.Safeguarding@nhs.net

OFFICE USE

Copy of plan sent by health to (Tick)	**Copy of plan sent by Social Care to**
☐ Social care ☐GP☐SN/HV	☐Social worker ☐IRO
Date:	