Appendix 8: The latest version of data collection forms

Australian Government
Department of Health and Ageing

NT Aboriginal and Torres Strait Islander CHILD HEALTH CHECK

Community Name: _____

Community Identification No.: _____

Date: _____

Patient details

First name: _____

Family name: _____

Other name: _____

Medicare number: _____

School year: _____

Name of school: _____

_____

Is the patient of Aboriginal or Torres Strait Islander origin? Yes, Aboriginal ☐

(For persons of both Aboriginal and Torres Strait Islander origin, mark both Yes boxes) Yes, Torres Strait Islander ☐

Current contact details

Phone: _____

Address: _____

_____

_____

Parent/carer

Name: _____

Phone: _____

Address (if different to above): _____

_____

Alternative community contact details

Name: _____

Phone: _____

Address: _____

_____

Patient consent/parent or carer consent

Explanation of health check given ☐

Explanation of how health check data will be used ☐

(This health check is funded by the Commonwealth Government. The health check form will be retained by your clinic. A copy of the form will be provided to the Commonwealth Government so it can evaluate this program and improve services. The Commonwealth Government may share this information with the Northern Territory Government to see if you receive the follow-up services you need. The front page with your name on it will stay with your health service and not be given to the Commonwealth Government. The data will not be reported in a way that could identify you).

Patient/parent/carer consent for sharing of health information with regular health service

Can we look at your clinical medical record to help complete this health check? Yes ☐ No ☐

Can we give the results of this health check to your regular health service? Yes ☐ No ☐

If Yes, which clinic?

_____

Who received consent

GP ☐

Practice Nurse ☐

Health Worker ☐

Other (please specify) ☐

_____

Would you like a written copy of the health check and recommendations for you and your child? Yes ☐ No ☐

HRN _____ Community ID No _____

Please fill in HRN and Community ID Number on this page

Patient details

Date of health check _____ (dd/mm/yyyy)

1a Date of birth _____ (dd/mm/yyyy)

1b Age group (0-5) ☐ (6-11) ☐ (12-15) ☐

2 Sex Male ☐ Female ☐

Details of Doctor conducting check

3 Name _____

4 Doctor employed by

DoHA Child Health Check Team ☐

Local Health Service ☐

Previous Health Checks

5a Has the child had a previous Medicare item 708 health check? Yes ☐ No ☐ Unsure ☐

5b If Yes, date of last health check _____ (dd/mm/yyyy)
(Note: must be more than 9 months ago – If less than 9 months this health check is not required)

6a If the child is <1 year, have they received a newborn check? Yes ☐ No ☐ Unsure ☐

6b If Yes, date _____ (dd/mm/yyyy)

6c Please specify any outstanding follow-up

_____

_____

7a If the child is aged 5-15 years, have they had a Healthy School Age Kids screening in 2007? Yes ☐ No ☐ Unsure ☐

7b 5 years ☐ 10 years ☐ 15 years ☐ Annual (for other ages) ☐ Unsure ☐

7c Please specify any outstanding follow-up

_____

_____

8a If the child is aged 0-5 years, have they had a full Growth Assessment and Action check in the last six months? Yes ☐ No ☐ Unsure ☐

8b If Yes, date of last Growth Assessment and Action check _____

8c Please specify any outstanding follow-up

_____

_____

9a Has the child had a Paediatric review in the last 12 months Yes ☐ No ☐ Unsure ☐

9b Has the child had a DMO/GP review in the last 12 months Yes ☐ No ☐ Unsure ☐

Immunisation Status

10 Is the child's immunisation status up to date for their age group? Yes ☐ No ☐ Unsure ☐

Check patient's immunisation record, health centre records, or call NT Immunisation Helpdesk (Central Region 08 89516928 or 08 89228292, Top End Region 08 89228893)

11 Which vaccines have not yet been received?

Age due	Circle overdue vaccines			
Birth	Hep B	BCG		
2 months	Hib	Prevenar	InfanrixPenta	Rotavirus
4 months	Hib	Prevenar	InfanrixPenta	Rotavirus
6 months	Prevenar	InfanrixPenta		
12 months	Hib	MMR	Men C	Hep A
18 months	Varicella	Hep A	Pneumovax23	
4 years	MMR	Infanrix/IPV		
13 years	Boostrix (dTpa)	Varicella *(if not given before or no history of chicken pox)*		
15 years	Pneumovax 23			
10-15 years (female)	HPV 1st dose	HPV 2nd dose	HPV 3rd dose	

Medical History *Obtain from clinic records*

If the child is aged 0-5 years, give birth history

12 What was the mode of delivery? _____

13 Gestation (weeks) _____

14 Birth weight (grams) _____

15a Any complications during or shortly after the delivery? Yes ☐ No ☐ Unsure ☐

15b If Yes, please specify

_____

_____

For children in all age groups give relevant family medical history

16 Show medical conditions for the patient's parents and grandparents:

Diabetes Yes ☐ No ☐ Unsure ☐

CVD Yes ☐ No ☐ Unsure ☐

Rheumatic heart disease Yes ☐ No ☐ Unsure ☐

Other (please specify) Yes ☐ No ☐ Unsure ☐

_____

_____

Past medical history, hospitalisations and injuries

Use health centre records if required

17 Patient's medical history

Growth faltering	Yes ☐	No ☐	Unsure ☐
Recurrent chest infection	Yes ☐	No ☐	Unsure ☐
Pneumonia	Yes ☐	No ☐	Unsure ☐
Rheumatic heart disease	Yes ☐	No ☐	Unsure ☐
Rheumatic fever	Yes ☐	No ☐	Unsure ☐
Asthma	Yes ☐	No ☐	Unsure ☐
Ear infections/otitis media	Yes ☐	No ☐	Unsure ☐
Skin infections	Yes ☐	No ☐	Unsure ☐
Disability	Yes ☐	No ☐	Unsure ☐
Other (please specify)	Yes ☐	No ☐	Unsure ☐

18 **Current health problems/issues** (use health centre records if required)

19 **Allergies/drug intolerances** (use health centre records if required)

20 **Current medications** (including prescription and over the counter)

Relevant Developmental/ Social History

21a Who does the child live with? _____

21b Who is the primary carer of the child? _____

22a Any concerns about hearing/listening/talking? Yes ☐ No ☐ Unsure ☐

22b If Yes, please specify

_____

_____

23a Any concerns about vision? Yes ☐ No ☐ Unsure ☐

23b If Yes, please specify

_____

_____

24a Any concerns about nutrition? Yes ☐ No ☐ Unsure ☐

24b If Yes, please specify

_____

_____

25a Any concerns about physical activity? Yes ☐ No ☐ Unsure ☐

25b If Yes, please specify

_____

_____

Education

If the child is aged 0-5 years, give early childhood education

26 Indicate whether the child attends any of the following:

Play group	Yes ☐	No ☐	Unsure ☐
Childcare centre	Yes ☐	No ☐	Unsure ☐
Jet crèche	Yes ☐	No ☐	Unsure ☐
Preschool	Yes ☐	No ☐	Unsure ☐
Other (please specify)	Yes ☐	No ☐	Unsure ☐

_____

If the child is aged 6-15 years, give educational progress

27a Does the child attend school? Yes ☐ No ☐ Sometimes ☐

27b If Yes, what year or composite group? _____

27c If No, what level completed? _____

28a Any concerns about learning or behaviour identified by parent/caregiver? Yes ☐ No ☐ Unsure ☐

28b If Yes, please specify

_____

_____

Smoking

29a Does anyone living in the household currently smoke regularly (at least once per day)? Yes ☐ No ☐ Unsure ☐

29b If Yes, does anyone smoke inside the house regularly? Yes ☐ No ☐ Unsure ☐

29c If Yes to the above, please state relationship to the child? _____

29d If Yes, do they want assistance to quit? Yes ☐ No ☐ Unsure ☐

Current Housing Situation

30 How many people usually sleep at the house (inside and outside)? _____

31 How many bedrooms does the house have? _____

32 Does the house have running water? Yes ☐ No ☐ Unsure ☐

33 Does the house have a working refrigerator? Yes ☐ No ☐ Unsure ☐

34a Does the house have a working toilet? Yes ☐ No ☐ Unsure ☐

34b If Yes, how many? _____

35 Does the house have a working bath or shower? Yes ☐ No ☐ Unsure ☐

36 *__Stressful Life Events__ (eg family deaths, exposure to violence, illness of primary carer)

_____

_____

_____

_____

_____

_____

_____

* ***Prompt questions could include***

- *Are you having a hard time in your life?*
- *What are your worries?*
- *Any sorry business, what makes you sorry?*
- *Any fighting, drinking too much grog, is there lots of gambling, is there enough money for food, what do you do with your time, do you get lazy (this is how boredom is expressed)?*

History Relevant to Specific Age Groups

Note: If child is aged 6–11 years, please go to Medical Examination section (page 10). If the child is aged 12–15 years, please go to Adolescent section (page 9).

If the child is aged 0–5 years complete this section *(Write N/A if not relevant)*

Mother's pregnancy

37a Did the mother attend antenatal care during the pregnancy? Yes ☐ No ☐ Unsure ☐

37b If Yes, where did she attend antenatal care? _____

38a Were there any complications during pregnancy? Yes ☐ No ☐ Unsure ☐

38b If Yes, please specify

_____

_____

39a Were there any issues with health care during pregnancy? Yes ☐ No ☐ Unsure ☐

39b If Yes, please specify

_____

_____

_____

_____

If the child is aged <2 years, give nutrition details

40a Was the child ever breastfed? Yes ☐ No ☐ Unsure ☐

40b Is the child currently breastfeeding? Yes ☐ No ☐

40c If No, what age was breastfeeding stopped? _____ months

41a Was the child ever bottle fed? Yes ☐ No ☐ Unsure ☐

41b Is the child currently bottle fed? Yes ☐ No ☐

41c If No, what age was bottle feeding stopped? _____ months

42a Any worries about feeding? Yes ☐ No ☐ Unsure ☐

42b If Yes, please specify

_____

43 Since this time yesterday has the baby/child had

Breast milk (if breastfeeding)	Yes ☐	No ☐
Baby Formula	Yes ☐	No ☐
Milk (tin/powdered/fresh)	Yes ☐	No ☐
Tea	Yes ☐	No ☐
Water	Yes ☐	No ☐
Soft drink/flavoured water/cordial/fruit juice	Yes ☐	No ☐
Other foods or drinks (please specify)	Yes ☐	No ☐

_____

_____

If the child is aged <1 year, give risk factors for SIDS

44 Indicate whether any of the following risk factors for SIDS are relevant for this child:

Prone sleeping	Yes ☐	No ☐	Unsure ☐
Soft sleeping surfaces and loose bedding	Yes ☐	No ☐	Unsure ☐
Overheating	Yes ☐	No ☐	Unsure ☐
Smoking	Yes ☐	No ☐	Unsure ☐
Bed sharing	Yes ☐	No ☐	Unsure ☐

If the child is aged 0-5 years, give history of neonatal screening for hearing

45a Did the child receive neonatal screening for hearing? Yes ☐ No ☐ Unsure ☐

45b If Yes, please specify _____

Development (achievement of age-appropriate milestones)

46a Any concerns with Personal-Social development (eg smile, plays, indicates want)? Yes ☐ No ☐

46b If Yes, please specify _____

_____

47a Any concerns with Gross Motor development (eg rolls over, sits, stands, walks, jumps, balances)? Yes ☐ No ☐

47b If Yes, please specify _____

_____

48a Any concerns with Fine Motor-Adaptive development (eg grasps objects, pincer grasp, stacks objects)? Yes ☐ No ☐

48b If Yes, please specify _____

_____

49a Any concerns about language (e.g. laughs, turns to voice, speech, words)? Yes ☐ No ☐

49b If Yes, please specify _____

_____

50a Does the parent/carer have any concerns about their infant/child's development? Yes ☐ No ☐

50b If Yes, please specify _____

_____

51 Mother's/primary carer's current well being (support network, stressors/mood, general health)

_____

_____

52 Other history of relevance

_____

_____

If the child is aged 12-15 years, complete this adolescent section *(Write N/A if not relevant)*

Alcohol

53a Any concerns about alcohol (patient drinking alcohol at a risky or harmful level)? Yes ☐ No ☐ Unsure ☐

53b If Yes, please specify _____

Smoking/tobacco

54a Does the patient smoke regularly, that is, at least once per day? Yes ☐ No ☐ Unsure ☐

54b If Yes, how many per day? _____

Other substance use

55a In the last 12 months did the patient use prescription medicines for non-medical purposes? Yes ☐ No ☐ Unsure ☐

55b If Yes, please specify details (eg type of drug, when)

_____

56a In the last 12 months did the patient use other substances/illicit drugs? Yes ☐ No ☐ Unsure ☐

56b If Yes, please specify details (eg type of substance, when)

_____

57a Does the patient show signs of depression/anxiety/self harm Yes ☐ No ☐

57b If Yes, please tick all appropriate boxes

Anxiety ☐

Depression ☐

Self harm ☐

57c If Yes, specify details: _____

_____

General well being

58a Please rate the patient's general well being Good ☐ Poor ☐

58b If Poor, specify issues _____

_____

Sexual and reproductive health (if applicable)*

Only enquire about, and approach this topic in an appropriate and culturally sensitive manner

59a Is the patient sexually active? Yes ☐ No ☐ Unsure ☐

59b If Yes, does the patient use contraception? Yes ☐ No ☐

59c If Yes, specify details: _____

59d Is the patient at risk of STIs? Yes ☐ No ☐

59e If Yes, specify details: _____

_____

*(*NB: Please ensure that confidentiality/mandatory reporting procedures as per NT legislation have been explained when relevant and necessary.)*

60 Other history considered necessary _____

_____

For children in all age groups give medical examination details

61 Child's weight _____ kg

62 Child's height _____ cm

63 If the child is aged <3 years or if clinically indicated, give head circumference _____ cm

64 If the child is aged 0-5 years is there evidence of growth faltering, i.e. crossing percentiles? Yes ☐ No ☐

(Plot and interpret growth curve)

65 Blood Pressure (please ensure correct cuff size) _____ (if clinically indicated)

66 Child's pulse rate and rhythm:

Normal ☐

Abnormal ☐

Equal ☐

67a If the child is aged 6-15 years, give visual acuity details

Right 👁 6/__ Left 👁 6/__

(Refer to optometrist/ophthalmologist if unable to read 3 symbols on 6/12 line or 2 lines or more difference, and if HSAK referral not identified)

67b If any abnormality detected was it previously known? Yes ☐ No ☐

68 If the child is aged <8 weeks was red reflex in newborn?

Normal ☐

Abnormal ☐

If the child is aged 6-15 years, give details of trachoma testing
(Only if no HSAK screening in 2007 and trainer screener available)

69a Was the child screened for trachoma? Yes ☐ No ☐

If Yes, please circle all findings

Right 👁 TF, TI, TS, TT, CO, no abnormality Left 👁 TF, TI, TS, TT, CO, no abnormality

69b If any abnormality detected was it previously known? Yes ☐ No ☐

70a Ears

Otoscopy results for the patient

Right ear

Intact ☐

Wet perforation ☐

Dry perforation ☐

Bulging ☐

Other (please specify) ☐

_____

Left ear

Intact ☐

Wet perforation ☐

Dry perforation ☐

Bulging ☐

Other (please specify) ☐

_____

70b If any abnormality detected was it previously known? Yes ☐ No ☐

Gums and teeth

71 Does the child participate in 'Strong Teeth For Little Kids'? Yes ☐ No ☐

72 Oral health issues for the child:

Untreated caries	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐
Gum disease	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐
Other (please specify)	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐

_____

73 Has the child accessed dental services (dentist or dental therapist) in the last 2 years? Yes ☐ No ☐

Skin problems

74 Does the child have any of the following skin problems:

Sores (more than 3)	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐
Scabies	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐
Ringworm	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐
Other (please specify)	Yes ☐	No ☐	If Yes, was this previously known?	Yes ☐	No ☐

_____

For children in all age groups perform cardiac auscultation

75a Child's cardiac health:
Abnormality detected Yes ☐ No ☐

75b If Yes, please specify _____

_____

If the child is aged 6-15 years

76a Does the child have a known congenital murmur? Yes ☐ No ☐

76b Has the child been screened for RHD? Yes ☐ No ☐

76c Does the child have a known problem with Rheumatic Heart Disease? Yes ☐ No ☐
(Check on review list and having Bicillin 4 weekly).

If cardiac abnormality is detected and is of urgent clinical concern discuss immediately with DMO/Clinical Advisor; if the child is aged <5 years refer to Paediatrician.

For children in all age groups perform respiratory examination

77a Child's respiratory health:
Abnormality/respiratory illness detected Yes ☐ No ☐

77b If Yes, please specify _____

_____

77c Was this abnormality/respiratory illness previously known Yes ☐ No ☐

Abdominal examination (if clinically indicated)

78a Child's abdomen:
Abnormality detected Yes ☐ No ☐

78b If Yes, please specify: _____

_____

Full newborn examination
(Only to be performed if child aged under 2 months, and newborn check is not recorded as done previously).

79 Was a full newborn examination performed today? Yes ☐ No ☐

80 Observed interaction between parent/carer and child (if indicated)

_____

_____

_____

_____

_____

81 Other examinations conducted by the team

_____

_____

_____

_____

Investigations

Investigation	Tests done	**Arrangements** (eg referral details)
82 Blood Please do: 1 Finger prick Hb test if not done in last 6 months or if <110g/L at last measure. If Hb <90g/L, do FBC. 2 BSL if indicated for adolescents	Hb results: _____ g/L BSL results: _____ mmoL Other: _____	
83 Urinalysis Please do 1 Dipstick for proteinuria for 10 to 15 year old children. 2 For other age groups as indicated		
84 Echocardiogram Arrange if new cardiac abnormality detected		
85 Other (as required)		

Interventions as required

86 Specify treatment provided, including any medications prescribed

87a Was a clinic follow-up required for this patient? Yes ☐ No ☐

87b If Yes, specify date of appointment and details _____

_____

88a Were any vaccinations provided during this health check? Yes ☐ No ☐

88b If Yes, specify details _____

89 Were any referrals provided? Yes ☐ No ☐

89b If Yes, specify details

- Paediatrician ☐
- Dental ☐
- ENT ☐
- Tympanometry and Audiology (If bilateral/large perforations and/or concern about hearing/speech) ☐
- Optometrist/Ophthalmologist (if unable to read 3 symbols on 6/12 line or 2 or more line differences between eyes) ☐
- Social Worker ☐
- Mental health services ☐
- Drug and Alcohol ☐
- Occupational therapist ☐
- Speech therapist ☐
- Physiotherapy ☐
- FACS ☐
- Other (please specify) ☐

_____

90 Were new arrangements (treatment/follow-up/referral) required for previously known problems? Yes ☐ No ☐

91 Liaison with school/other service provider

_____

_____

Was advice given to the patient on:

92 General

Physical activity/ exercise	Yes ☐	No ☐
Diet and nutrition	Yes ☐	No ☐
Smoking	Yes ☐	No ☐
Alcohol	Yes ☐	No ☐
Parenting	Yes ☐	No ☐
Sun protection	Yes ☐	No ☐
Injury prevention	Yes ☐	No ☐
Mental health issues	Yes ☐	No ☐
Social issues (possible action plan with health services)	Yes ☐	No ☐
Learning difficulties/educational issues	Yes ☐	No ☐

93 Infant issues

Breast/ bottle feeding	Yes ☐	No ☐
SIDS prevention	Yes ☐	No ☐
Support for Mother	Yes ☐	No ☐

94 Adolescent issues

Substance use (including tobacco) prevention and treatment	Yes ☐	No ☐
Safe sex advice	Yes ☐	No ☐

95a Other interventions/advice Yes ☐ No ☐

95b If Yes, please specify _____

_____

_____

Please Sign As Appropriate

Name of Doctor: _____ Signature: _____

Name of Nurse: _____ Signature: _____

Name of Aboriginal Health Worker: _____ Signature: _____

Name of Social Worker: _____ Signature: _____

Summary Assessment of Patient

Based on consideration of evidence from patient history, examination and results of any investigation

A copy of this summary sheet can be given to the patient

Major Health Problems and Issues

Intervention Action/ Recommendations

Pre Populated Chart Review Form (Legend: Y=Yes, N=No, U=Unknown)

Community ID:

HRN:	DOB:	SEX:	CHC DATE:	Form #:
Conditions identified at CHC: 1:	2:	3:	4:	5:
(see Instructions for Use page) 6:	7:	8:	9:	10:

Initial chart review (see Step 2 on Instructions page) *Date of Initial chart review*: ___/ ___/ _____ (dd/mm/yyyy)			**Action Plan** (see Step 3 on Instructions page)		**Exit chart review** (see Step 5 on Instructions page) *Date of Exit chart review*: ___/ ___/ ____ (dd/mm/yyyy)		
Referral(s) made or follow-up identified at CHC	**For what condition(s) was the child referred or required follow- up?** (list all conditions that relate to each referral; see Instructions for list of terms)	**Has child been seen for this condition ?**	**Is further action required ?**	**If yes, which clinician does child need to see for this condition?** (see Instructions for list of terms)	**Has child been seen for condition since Initial chart review?**	**Is further action required ?**	**If yes, which clinician does child need to see for this condition?** (see Instructions for list of terms)
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
………………..		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
…………………		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
		Y / N / U	Y / N / U		Y / N / U	Y / N / U	
Any other conditions currently requiring follow-up? (see Step 2)	Yes / No / Unsure						
If yes, specify condition(s):			Yes		Y / N / U	Y / N / U	
			Yes		Y / N / U	Y / N / U	
			Yes		Y / N / U	Y / N / U	
			Yes		Y / N / U	Y / N / U	
			Yes		Y / N / U	Y / N / U	

1 (version 5)

Version 5: NTER CHCI *AUDIOLOGY* SERVICES FORM

1. Organisation Details

Date of service: _____/_____/_____ (dd/mm/yyyy)

ID of Community or Town Camp where this service was provided: _____

2. Child Details

HRN: _____ Date of Birth: _____/_____/_____ (dd/mm/yyyy) Sex: □ Male □ Female

3. Previous Audiology check

Has the child had a previous Audiology check since 11/07/2007?
□ Yes, please specify date: ____/____/_____ (dd/mm/yyyy) If child had more than one previous check, refer to latest one only.
□ No (go to question 4)
□ Unsure (go to question 4)

If Yes, has any ear health intervention occurred since that check? □ Yes □ No □ Unsure
If Yes, specify the type of intervention *(please indicate all that apply)*?
□ Enhanced primary care
□ ENT consultation
□ Surgery
□ Other, please specify _____
□ Unsure
If there was a previous Audiology check, has there been any significant change in hearing levels since that check? □ **Yes** **If Yes, was there a** □ significant improvement **or** □ significant deterioration
□ No significant change
□ Unsure

4. Summary of audiology findings ***(only select one option under each heading)***

Hearing loss
□ None
□ Unilateral
□ Bilateral
□ Soundfield

Type of hearing loss
□ None
□ Conductive
□ Sensorineural
□ Mixed (both conductive and sensorineural)

Degree of hearing impairment (based on better ear)

(av. HTL)	*Sound Proof Conditions*	*Non-Sound Proof Conditions*
□ None	(0 – 15 dB)	(0 – 25dB)
□ Mild	(16 – 30dB)	(26 – 35dB)
□ Moderate	(31 – 60dB)	(36 – 60dB)
□ Severe	(61 – 90 db)	(61 – 90 db)
□ Profound	(91dB +)	(91dB +)

Middle ear condition

Right
□ None
□ Eustachian Tube Dysfunction
□ Acute Otitis Media
□ Otitis Media Effusion
□ CSOM
□ Dry Perforation
□ Other, please specify _____
□ Unsure

Left
□ None
□ Eustachian Tube Dysfunction
□ Acute Otitis Media
□ Otitis Media Effusion
□ CSOM
□ Dry Perforation
□ Other, please specify _____
□ Unsure

5. Action ***(please indicate all that apply)***

□ No further action required
□ Case management by Primary Health Centre
□ Case management by ENT
□ Ongoing monitoring by NT Hearing Services
□ Referral to Australian Hearing (rehabilitation)
□ Referral to Department of Education Employment and Training Hearing Advisory Support
□ Other, please specify _____

NTER CHCI DENTAL SERVICES DATA COLLECTION FORM

1. Organisation details

Date of Service: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)

ID of Community or Town Camp where this service was provided:

☐☐☐☐☐

2. Consent to provide information to the Commonwealth

This dental service is funded by the Commonwealth Government. Information relating to the dental services provided to you, including any treatment and follow up treatment you receive (for example, surgery) will be kept by your dentist and provided to the Australian Institute of Health and Welfare (AIHW). To ensure you receive any follow up services you need and to evaluate and improve this program, the AIHW may disclose the information it receives to the Commonwealth Government to enable this evaluation, improvement and follow up to occur. Your name will not be provided to the AIHW or the Commonwealth Government and your information will not be reported in any way which could identify you.

Consent given to provide information to the Commonwealth?

☐ Yes ☐ No

If consent is not obtained, no data to be sent to the AIHW.

3. Child's details

HRN: _____

DOB: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)

SEX: ☐ Male ☐ Female

(continued on next page)

Please provide HRN and date of service again: HRN:_____ Date of service:_____

4. Dental services provided

Indicate all services provided during this occasion of service

- ☐ 0: Diagnostic
- ☐ 1: Preventive
- ☐ 2: Periodontic
- ☐ 3: Surgery
- ☐ 4: Endodontic
- ☐ 5: Restorative
- ☐ 6: Crown or bridge
- ☐ 7: Prosthetics
- ☐ 8: Orthodontic
- ☐ 9: Other – please specify_____

5. Problems treated

Indicate all problems treated during this occasion of service

- ☐ 1: Assessment only
- ☐ 2: Oral health education
- ☐ 3: Untreated caries
- ☐ 4: Gum disease
- ☐ 5: Broken or chipped teeth due to trauma
- ☐ 6: Abnormal teeth growth
- ☐ 7: Missing teeth
- ☐ 8: Mouth infection or mouth sores
- ☐ 9: Dental hygiene (including plaque and calcification)
- ☐ 10: Other – please specify_____

6. dmft/DMFT and dmfs/DMFS scores

dmft: if less than 11 years old	d		m		f		dmft	
DMFT: if 7 years or over	D		M		F		DMFT	
dmfs: if less than 11 years old	d		m		f		dmfs	
DMFS: if 7 years or over	D		M		F		DMFS	

7. Follow-up requirements

Does this child require further follow-up in order to complete their treatment plan?

☐ Yes ☐ No