

Name		DOB		NHS Number	
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**COMPLETION OF INITIAL HEALTH ASSESSMENT OF UNACCOMPANIED YOUNG PERSON:
FOLLOWING VIRTUAL ASSESSMENT UNDERTAKEN DURING COVID19 PANDEMIC**

- *This report should be attached to the Virtual Initial Health Assessment Summary report*
- *Any additional health recommendations to be noted and added to health care plan*
- *Review date if one year from Virtual Initial Health Assessment Appointment*

Young person's details			
First Name (s)		Family Name	
Date of Birth		Gender	
Age assessment being undertaken	Y / N **	NHS Number	
Legal Status / Current Legal Proceedings		Keyworker / Main contact at accommodation	
Young person's address			
Postcode			
Telephone number			
Reason for being Looked after		<i>Unaccompanied minor</i>	
Date of Virtual Initial Health Assessment			
Doctor carrying out Completion health assessment			
Summary of health concerns identified at Virtual Initial Health Assessment			

Social Services / Local Authority details	
Name of Social worker and team	
Telephone	
Email	
Name of Team Manager	

Consent for examination	
<i>Unless younger than 15 years, <u>the young person</u> should normally give consent for the examination and distribution of reports - assisted by the interpreter if necessary.</i>	
<p>I agree to having a medical assessment including limited physical examination (as explained by the medical practitioner) and to a health plan being produced with my involvement.</p> <p>Permission given for report / health plan to be copied to GP / Social worker (Summary) / Other (delete not applicable)</p> <p>Print name: _____ Signature: _____</p> <p>Date: _____</p>	

Date of assessment		Venue	
Those present at assessment and relationship to young person			



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Was the young person given an opportunity to see the Dr/Nurse without the carer?					Y / N		
Name of interpreter / Contact agency							
Language							
Any new health concerns, appointments, screening or immunisations since virtual assessment							
Physical examination							
Height:	cm	centile	Weight:	kg	centile	BMI:	centile
General appearance:							
Oral Health:							
Skin:							
BCG scar		Y / N	Mantoux undertaken	Y / N	If Yes any action needed	Y / N	
ENT:			Eyes:				
Chest:			Cardiovascular system:				
Abdomen:			Pubertal status:				
Nervous system:			Musculoskeletal system:				
Summary of physical findings:							

ANY ADDITIONAL RECOMMENDATIONS OR UPDATES TO HEALTH CARE PLAN

Date of next health assessment:			
Issues	Action required	By when (date)	Named person responsible
Assessment and recommendations for health plan completed by:			
Name:		Qualifications:	Y/N
Title / Role:		Level 3 training:	
Office email:		GMC Number:	
Signature:		Office tel:	
		Date:	

Copy of completion report to:
Young Person
GP
File
Social Worker – check consent

