Name		DOB		NHS Number	

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		*Unaccompanied minor*	
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 *Unless younger than 15 years, the young person should normally give consent for the examination and distribution of reports - assisted by the interpreter if necessary.*
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. Permission given for report / health plan to be copied to GP / Social worker (Summary) / Other (delete not applicable) **Print name:** **Signature:** **Date:**

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

Name		DOB		NHS Number	

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 ENT: Chest: Abdomen: Nervous system:		Mantoux undertaken Y / N Eyes: Cardiovascular system: Pubertal status: Musculoskeletal system:		If Yes any action needed Y / N	
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:** **Level 3 training:**	Y/N
Title / Role:		**GMC Number:**	
Office email:		**Office tel:**	
Signature:		**Date:**	

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