NH606661 190813

BINDING MARGIN - NO WRITING

SMR060720

NSW GOVERNMENT | Health

Facility:

OUT OF HOME CARE HEALTH MANAGEMENT PLAN

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. ______/______/______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date child or young person entered out of home care:	Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander ☐	Cultural / Religious Background:	Preferred Language: Interpreter Required: Yes ☐ No ☐ Type:

This Health Management Plan developed following: Primary Screen (2a) ☐ Comprehensive Health Assessment (2b) ☐	Date Primary (2a) Screen completed:	Comprehensive Assessment (2b) required: Yes ☐ No ☐	Date Comprehensive Assessment (2b) completed: Yes ☐ No ☐

Date this Health Management Plan will be reviewed on:

(Minimum of 6 monthly for children under 5 years and annually for children / young people over 5 years or as clinically indicated)

Within 6 months Review Date: ______________________

Within 12 months Review Date: ______________________

Other (based on clinical assessment) Review Date(s): ____

Out of Home Care Health Management Plan Number:

ASSESSMENTS THAT INFORM THIS HEALTH MANAGEMENT PLAN

Type of Assessment conducted *(e.g. medical/ physical, developmental, speech, mental health)*	Date conducted	Assessment Conducted by		
		Name	Designation	Contact details

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OUTCOMES FOLLOWING ASSESSMENT AND TARGETED INTERVENTIONS *Health issues requiring follow-up*

Health Issue (s) identified	Actions and Tasks required *(eg referral to specialist)*	By whom *(Name, designation contact details)*	Timeframe for completion

Additional notes/comments:

Who participated in the development of this Health Plan?

Did the child or young person participate in the development of this Health Management Plan **Yes** ☐ **No** ☐

Did the carer participate in the development of this Health Management Plan **Yes** ☐ **No** ☐

Other Participants:

Name	Role	Organisation (if applicable)

HEALTH MANAGEMENT PLAN PREPARED BY:

Name	Phone	Email	Designation:	Signature:	Date: