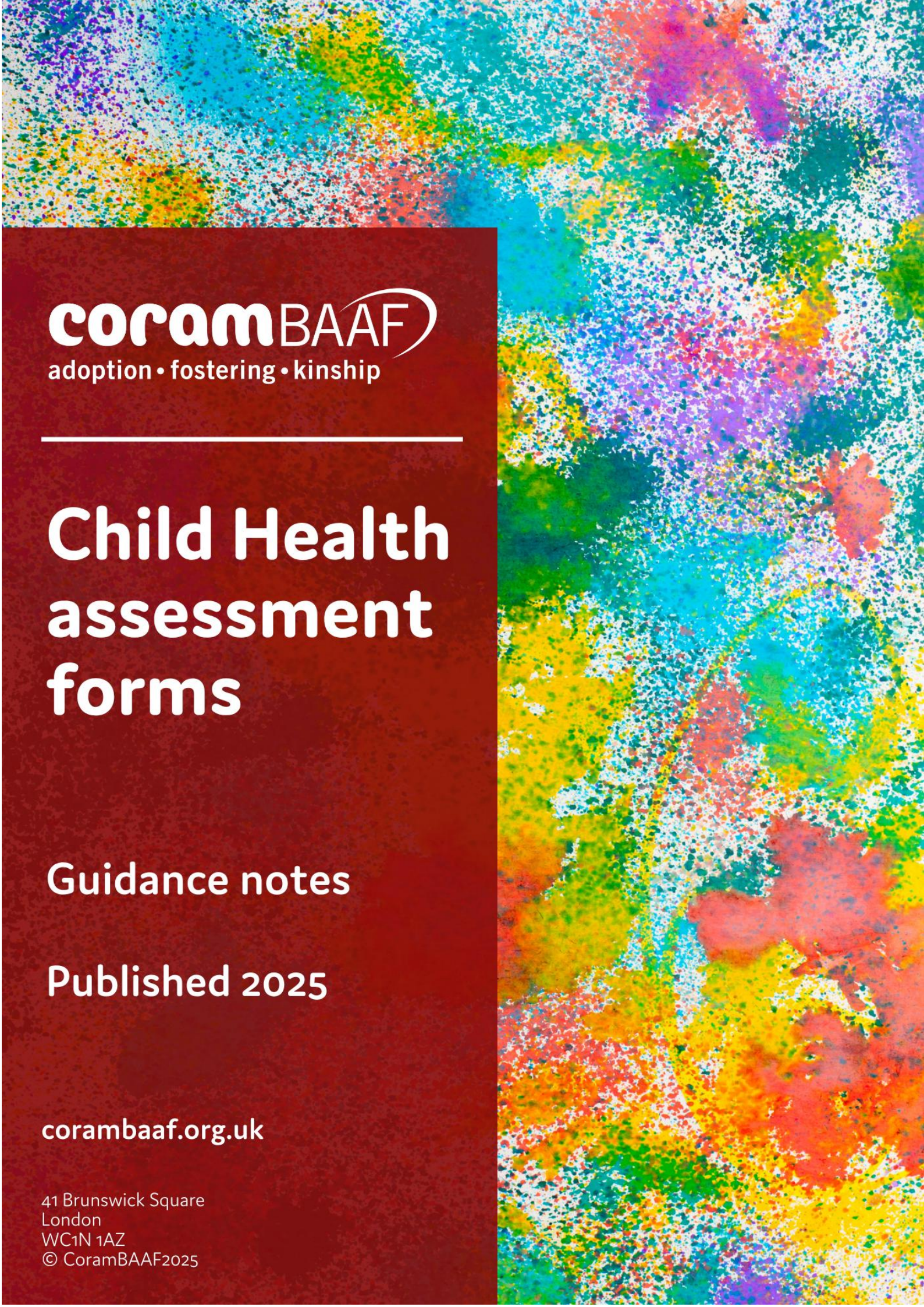

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Child Health assessment forms

Guidance notes

Published 2025

corambaaf.org.uk

41 Brunswick Square
London
WC1N 1AZ

Child Health assessment forms

Guidance notes and additional resources

Published 2025

Published by CoramBAAF, 41 Brunswick Square, London WC1N 1AZ.

Contents

Appendices

Introduction

CoramBAAF publishes a suite of forms to be used in the health assessment processes when children are in care. These have been developed in consultation with our health professional members.

The latest versions were published in 2025 and can be used by organisations that hold a current license and their partner organisations. They are designed to be used in the UK. (Scotland-specific and Welsh language versions will also be available.) The new forms are accessed via the license holder and CoramBAAF has informed local authorities that they are now available.

Comprehensive, high quality and child friendly health assessments are essential in ensuring children's health needs are identified and supported.

The forms are produced as Word documents which can be downloaded, completed and transferred digitally. They are designed to assist local authorities and health organisations in complying with regulations and statutory guidance.

Health and social care providers use a wide range of digital record keeping systems. The CoramBAAF licence terms specify that the child health forms can be integrated into these systems, and this is recommended. Further guidance on using CoramBAAF forms in electronic patient records is included in Appendix 1.

CoramBAAF recommends that health and social care providers work locally together to ensure effective processes, and choose which forms are required in combination with their digital systems. (See Appendix 1.) In areas where health and social care practitioners access a shared record, for example, it may not be necessary to use all the forms published.

It is important to remember that many children move across local authority borders so this should be considered in the development of local protocols.

Initial health assessments (IHA)

The new **Initial Health Assessment Toolkit** is divided into four separate templates:

- Referral and consent
- Health history
- Health appointment record
- Health plan

In addition, there are optional tools and resources that can be used by practitioners in conjunction with the base templates. **The aim is to create an individual assessment for each child.**

Administration process

We would recommend that local areas agree a **notification** process that is triggered when a child enters care, i.e. social care needs to inform health. We have not produced a template for the notification as we would expect this to be a digital process and to take place within 24 hours.

We would suggest that as soon as a notification is received that the health team identifies a potential appointment date and starts preparing information.

Referral and consent form

This should be completed by the child's social work team and sent to the identified health team/service, within five days of the child entering care. Social care should retain a copy of the referral form.

We have published a **parent information leaflet** to assist the social worker (SW) when discussing health assessments with parents and obtaining consent where required.

See further information on consent (Appendix 2).

Health practitioners can only provide quality health assessments if they have access to critical information that can often only be supplied/shared by social care.

If all the information listed on the CoramBAAF referral form is already available on another social care document, this could be supplied instead. Unnecessary duplication should be avoided.

One referral and consent form will be required for each child; however, content that applies to all children in a sibling group that enter care simultaneously can be copied to multiple forms.

Other information to be obtained at this time includes family health details and neonatal (birth) history for the child, including maternal antenatal information. The **Parental History** (Form PH) and **Mother and Baby** (Forms M and B) forms should be used. A local process will be needed, to agree how this information is requested. If the health team has access to maternal and neonatal information on local record systems, Forms M/B may not be required. Local areas may be able to work with hospital trusts to extract information digitally and provide the information required in Forms M and B.

Carers and young people questionnaires

Local teams can use CoramBAAF **carers and young people questionnaires**, which should be requested by social care at the same time as referral is made for the IHA appointment.

Health history form

Following receipt of the referral form, the health team can start completing the health history form. This is a **new recommendation**, and it is appreciated that teams will need to consider resources and ways of working.

Healthcare professionals should compile a history of the looked after child or young person's health from the information they hold in the health records and additional information given to healthcare professionals from other teams, to give practitioners and carers a clear sense of their past, present, and likely future physical and mental health needs.

National Institute for Health and Care Excellence (NICE), 2021

Reason for introduction are:

- To implement NICE guidance.

- Young people have often said they do not want to go through repeat questions and retell their story.
- Feedback from practitioners highlighted that information about a child's health history is lost over time when recorded in IHA forms as they are used now.
- It will form the basis of the care leavers' health summary.
- To ensure best use is made of the child's appointment, leading to high quality assessments.
- To make best use of the skills available in health teams.

The health history template should be completed by the health team from records and referral information as much as possible, in advance of the child's appointment.

Forms PH, M and B will also contribute to the information in the health history. It may be possible with electronic records for much of the information to be populated into the health history form directly from other digital sources. It is imperative that the health history form is situated on the child's health and social care record where it remains easily accessible and viewable throughout the child's time in care.

The health assessment appointment

The practitioner completing the assessment should have the following documents available for reference.

Essential

- Referral and consent
- Health history
- PH (or equivalent information)
- M and B (or equivalent information)

Suggested

- Carers questionnaire
- Young people questionnaire

Health appointment forms

These templates are designed to provide a record of the child/young person appointment, with a suggested structure to follow. They are designed to be used by a practitioner new to this area of work; more experienced staff will not need the prompts.

Practitioners should develop approaches that ensure the session does not become a list of questions. The forms do contain questions and topic sections, but these are provided as a background framework (aide memoire). Much of the information required can be elicited within a conversation.

An appropriate approach would include:

- Introductions
- Checking out (who is with the child, etc)
- "Breaking the ice" (engaging children and young people)
- Child-led discovery of information, exploring issues (use games and pictorial aids)

- Involving the carer (social worker or parent if present)
- Agreeing with children and young people to carry out physical examination
- Identifying areas that need further exploration; consider use of additional screening tools
- Offering children and young people a chance to speak without other adults present
- Coming to a conclusion and making a plan

The forms are not titled health 'assessment' as young people have expressed that they do not like the word assessment in this context. Instead, we have labelled them 'health appointment'.

The consultation is likely to be enhanced if carers and young people complete questionnaires prior to the appointment. Children/young people should be supplied with helpful information with their invite, so they know what to expect when they attend. Leaflets and information should be designed specific to the local service provision.

To record the consultation, the clinician can choose an appropriate template depending on the child's age/stage of development. There are also template choices that may be more suitable for asylum-seeking young people and children with special educational needs and disabilities.

Health plan

The clinician will also complete this document at the appointment. Where information has been sourced prior to the consultation, e.g. information obtained from questionnaires or the health record, this can be inserted straight onto the health plan in preparation.

On this template, the clinician will summarise the health information and consider any implications for now and the future. The clinician must review all health history and the information supplied by social care, and particularly consider the impact of trauma on health.

Actions and health promotion tips will be added to the plan. The plan should be discussed with the child/young person and carers/parents/social worker if in attendance.

Administration following appointment

The health plan, health history and record of appointment should be shared with the child's social worker and GP. Any notes/records that need to remain confidential should be kept in the secure section of the child's health record.

The health plan will normally be shared with the young person and carer. The clinician will consider whether it is appropriate to share the health plan and health history with other professionals/services/family. Young people should be involved in decisions about sharing their information wherever possible. The local protocol should identify where the completed forms are stored in both social care and health record systems.

In some situations, the health professional completing the assessment may feel that they would like to share information/advice with the social worker/carer that would not be appropriate to share directly with the child/young person on the health plan. Health professionals may also obtain additional information after the health plan has been shared. In both these circumstances, we recommend that this information is shared in a separate clinical letter.

Review health assessments (RHA)

The new Review Health Assessment Toolkit is divided into three templates:

- Referral
- Health appointment record
- Health plan

Referral form

The social worker (or social work team) for the child should complete a referral form.

In some cases, no new consent section is required, as this will have been obtained previously at the IHA. However, as circumstances change, the social worker should review and decide what would be the appropriate consent relating to the current situation. The form is designed to assist. If a new consent section is required, a template is available (Appendix 2).

Carers and young people questionnaires

Local teams can use CoramBAAF carers and young people questionnaires, which should be requested by social care at the same time as referral is made for the RHA appointment.

The review health assessment appointment

The practitioner completing the assessment should have the following documents available for reference.

Essential

- Referral (plus new consent if required)
- Previous health plan
- Health History (where this has been completed)
- Previous IHA/RHA forms
- Strengths and Difficulties Questionnaire (SDQ)

Suggested

- Carer Questionnaire
- Young Person Questionnaire

Review health appointment forms

These templates are designed to provide a record of the child/young person appointment, with a suggested structure to follow. They are designed to be used by a practitioner new to this area of work; more experienced people will not need all the prompts.

Practitioners should develop approaches that ensure the session does not become a list of questions. The forms do contain questions and topic sections, but this is provided as a background framework (aide memoire). Much of the information required can be elicited within a conversation.

An appropriate approach would include:

- Introductions

- Checking out (who is with the child, etc)
- ”Breaking the ice” (engaging children and young people)
- Child-led discovery of information, exploring issues (use games and pictorial aids)
- Involving the carer (social worker or parent if present)
- Agreeing with children and young people to carry out any physical checks
- Identifying areas that need further exploration; consider use of additional screening tools
- Offering children and young people a chance to speak without other adults present
- Coming to a conclusion and making a plan

The forms are not titled health ‘assessment’, as young people have expressed that they do not like the word assessment in this context. Instead, they are labeled ‘health appointment’.

The practitioner can choose an appropriate template depending on the child’s age/stage of development. There is also a form that may be more suitable children with special educational needs and disabilities. The assessment is likely to be enhanced if carers and young people complete questionnaires prior to attending the appointment.

Health plan

The practitioner will also complete this document at the appointment.

Where information has been sourced prior to the consultation, e.g. information obtained from questionnaires or the health records, this can be inserted straight onto the health plan in preparation.

It is important that the practitioner considers all the child’s health history, including family history, at every health review, in order to ensure quality health plans. It may not be necessary to revisit some of this information with the child/young person, but referring back to the health history document is an essential component of the process.

On this template, the clinician will summarise the health information and consider any implications for now and the future. Actions and health promotion tips will be added to the plan. The plan should be discussed with the child/young person and carers/parents/social worker if in attendance.

Administration following appointment

The health history, record of appointment and health plan will be shared with the child’s social worker and GP. Any notes that need to remain confidential should be kept in the secure section of the child’s health record.

The local protocol should identify where the completed forms are stored in both social care and health systems.

Forms list

A full list of the health assessment forms is shown in Appendix 4. All templates are given a code for administrative purposes.

Links in forms

The new templates contain hyperlinks that lead to a guidance section on the website. This is to enable CoramBAAF to easily update guidance as clinical information changes. The webpage guidance is available in a collated version in Appendix 3.

Adoption

CoramBAAF health assessment forms are designed so the information collated during these processes also produces much of the medical information that is necessary and required by adoption regulations.

The medical adviser for adoption must prepare a summary report.

CoramBAAF plans to publish exemplar templates for medical adviser summary reports. The health history and health plan documents will form the basis for most medical adviser summary reports.

Consent for the medical adviser to write their report or to see the child for additional appointments for adoption pathway purposes should be provided by the adoption agency if required.

Child health forms project – why did we change the forms?

The last major revision of the health forms was in 2015, with minor updates in 2018.

A survey to health professionals was circulated in 2022. The response enabled the project team to identify requested changes. It became apparent that although many health providers were using the CoramBAAF forms, these were being used in a variety of formats, including versions integrated into many different electronic record systems.

Focus groups were convened with health professionals to further refine opinions and suggestions. Some issues reported about the CoramBAAF 2018 health forms were that they:

- were too long
- led to unnecessary duplication with 'sections B and C'
- did not flow well
- were not tailored to the needs of certain groups of young people
- were not young person-centred enough (in particular, the health plan)
- did not lead to a clear health history being readily available and sustained in health records; this included issues around the recording of risks related to fetal alcohol spectrum disorder (FASD)
- were not easily digitally compatible

Health professionals often noted that they did not have enough information about the child from social care or other sources before the initial health assessment.

Positive feedback on the forms noted that they:

- were compliant with statutory guidance and adoption regulations across the UK nations
- enhanced consistent practice UK-wide
- included comprehensive content
- included comprehensive guidance for completion (but this was seen as an issue if on the form itself)
- included brief prompts on the form that were helpful for less experienced staff

Child/young person feedback on health assessment processes was shared by health practitioners who had completed local work with young people, including children in care councils. Information was also available in research and published audits.

Key feedback from young people was that they often did not understand why they were attending a health assessment, and felt the whole process should be better explained so they could give valid consent.

The project team also utilised information obtained via other projects running in parallel, including the RCPCH/CoramBAAF development of standards for IHAs.

This enabled the project team to develop a new form design. The templates were shared with discrete practitioner groups who suggested amendments, before final versions were produced.

Challenges

Despite the intentions in the NHS plan to shift to systems fully enabled by modern technology, the multiplicity of digital patient records and social care digital systems presents significant challenge.

Many participants in this project have suggested the ultimate solution for children in care health assessments would be a national portal-style system. Unfortunately, this is far beyond CoramBAAF's resources and responsibility. Another suggested solution was for national provision of forms by digital providers directly into their systems. Although CoramBAAF has explored the possibility of working directly with digital record providers, the number of these companies is prohibitive, and this could not be pursued.

CoramBAAF appreciates that health care providers must work within their digital systems, and this means the new forms suite must be integrated by local digital support teams. This is more resource intensive than simply changing to use a new form. Therefore, CoramBAAF expects to see a "change" process, with the aim of the new templates being embedded in digital systems and in full use by 2026/2027.

Top tips for using the new forms

- Keep in mind that the aim is to complete an individual assessment for each child/young person; it will take time to adjust to choosing and using a variety of templates.
- Complete information directly onto the health plan as much as possible.
- Preparation for the appointment is key, especially to complete the health history before the IHA; this will require a shift in resource use in many areas.
- Remember, these are resources to be used flexibly; adapt during the appointment so that the conversation is child/young person-led.
- Plan and develop your local protocol jointly with social care.
- Engage your digital patient record experts and service as soon as possible.
- View our free CoramBAAF briefing sessions for more information about the forms.
- The forms are designed as a tool to meet the IHA standards.

CoramBAAF will publish a revised edition of our guide *Undertaking a Health Assessment* in 2026. Training in use of the new form templates will also be available.

References

Beckett L and Bond M (2024) 'Ascertaining risk of fetal alcohol spectrum disorder at initial health assessments for children in care', *Adoption & Fostering*, 47:4

NICE (2021) Overview | Looked-after children and young people | Guidance | NICE

Appendix 1: Integration of forms into digital systems

Although the forms can be downloaded and completed as Word documents, it is recommended that the templates are integrated into electronic patient record systems.

Advantages of integration

- Existing information on the child's record could populate the templates and vice versa
- The integrated templates could run with background coding, allowing data collection
- Dictation software could be utilised

Caveats

The content of the templates, including the order of sections, should not be altered substantially. They must remain identifiable as CoramBAAF templates.

Local protocol

This should:

- Specify the notification process.
- Specify the referral and administration process.
- Identify what digital record-keeping systems are used, and which professionals have access.
- Identify secure digital transfer methods.
- Agree a 'decliners' pathway where young people decide not to have a health assessment.
- Identify how parental health forms and mother and baby forms or information will be requested.
- Agree the method of applying signatures to templates where required, as per trust policy.
- Identify sections of the forms that can be prepopulated with local information.
- Ensure that staff know how to access the templates to be used.
- Specify how forms will be stored on health and social care systems when completed.
- Ensure that there is a clear process for when children move out of area.
- Identify which additional locally agreed screening tools are being used.
- Agree minor additions to templates, e.g. where this is required for local audit.
- Agree what information will be shared by social care regarding adverse childhood experiences (ACEs) and other social history.
- Include a blood-borne infection screening pathway.

Items to take into consideration when agreeing the local protocol:

Parental health forms/Form M (maternal information) should not be stored on the child's health record but can be stored in a "locked area" of a digital record system, accessible to the looked after children health team.

The health plan should form part of the child's care plan. It should be stored on the social care system where it is available for regular reference and review.

Suggestions for the decliners pathway

The health team may be able to offer alternative venues, alternative professional or online appointments. If young people do not wish to engage in any appointment at all, a record review can be

carried out. In most circumstances, this will be needed for the purposes of safeguarding the young person, ensuring that their carers are able to meet their ongoing and future health needs.

Appendix 2: Consent

CoramBAAF has reviewed the guidance they have published to date regarding obtaining consent for child health assessments. This has been updated, in response to feedback and with consideration of developments in the digital landscape and modern health care practice.

Previously, CoramBAAF published both a consent form and consent sections on initial and review health assessment forms. All required consents applying to the health assessment pathway will now be obtained and recorded on the new **referral and consent form**. There are several permissions to be obtained:

- Permission for the child/young person to be invited to, and have an appointment with, a health professional. This appointment involves a physical examination at IHA.
- Permission from birth parents to access, record and share their health information, where it is relevant to the child's health.

The health assessment

When a child/young person enters care, social care has a statutory requirement to arrange a health assessment . The social worker should explain this duty to the young person and those with parental responsibility. CoramBAAF has produced an information leaflet that can be shared with parents to assist these conversations.

Where a young person has the capacity to make their own decision about attending the appointment, the social worker should have the conversation directly with them and seek their permission, which can be recorded on the form. The young person can give verbal assent.

Where the child/young person cannot make their own choice, permission can be obtained from someone with parental responsibility.

In some cases, the local authority has (or shares) parental responsibility for the child/young person. In these circumstances, submission of the referral by social care to the health team is sufficient to proceed.

If neither of the two situations described above apply, another adult who has parental responsibility will need to give permission. The social worker should explain the statutory process to the appropriate individual. If the individual raises no objections, this can be recorded, and the referral can be submitted.

Where parents do not need to give consent for the health assessment, it is still good practice to ensure that they are fully aware of the processes.

The consent section is now worded so that initial permissions from parents (if required) are relevant for the entire care episode. However, practitioners should recognise that circumstances may change in terms of the legal situation regarding parental responsibility or the child/young person's ability to take their own decisions. There may also be changes in delegated authority arrangements over time. In requesting review health assessments, social care should consider these possible changes but often will not need to seek new permissions/consent.

Birth parents' health information

In respect of parents' health information, they will need to give consent for this information to be obtained, viewed and shared. This should be recorded on the referral and consent form.

Preparing children for appointments

Children and young people may be able to make their own decisions about whether they wish to attend their health appointment. The social worker should discuss this with them, explaining the benefits and reasons. Many areas have developed local resources, such as short online video clips encouraging young people to attend and aiming to allay any anxieties.

Appendix 3: Web guidance

Referral and consent form (guidance for social care)

Social workers and their administrative support play a key part in ensuring that all children and young people coming into care can access a health assessment as required by care planning regulations and statutory guidance.

A local protocol should be available for reference to guide the arrangement of appointments. It is imperative that this referral and consent form is completed fully so that health professionals can complete a quality assessment in a timely manner.

One referral and consent form is required for each child; however, content that applies to all children in a sibling group that enter care simultaneously can be copied to multiple forms. The referral form could be prepopulated with social work and health team details. The information supplied on this form will enable the health team to:

- retrieve and view health records and source important information
- plan how to conduct the appointment, and ensure that the appropriate adults are present
- identify health needs and risks, and, using a trauma-informed approach, put together a comprehensive health plan.

The amount of information held by social care will vary depending on the circumstances. Sharing information now may be very significant to the child's future wellbeing. An example is a mother's alcohol use in pregnancy – if this information is not shared now, this detail may be "lost". This may impact assessments regarding a child's development/health in future years.

Most of the information required in the form is self-explanatory. Below are some additional tips to aid completion.

Child information

It is important to complete both sex (assigned at birth) and gender identity boxes, as this information is required to identify health needs (e.g. appropriate screening) and health interventions, and is important where genetic detail is considered.

Parents

The **'other information'** field **can be used** to add any pertinent detail that health professionals need to know, e.g. parent deceased, in custody, lives abroad.

Details of living situation prior to entry to care

There are situations where a child/young person comes into care where they were not previously living with a birth parent. However, details of birth parents are still important as they may be needed to identify health needs for the child. If the child/young person has been living with other adults as their primary carer/s, identify this clearly on the form, e.g. living with adoptive parent, special guardian, private fostering.

Are there any restrictions on appointment time/place?

This applies to all those who will be invited to the appointment. For example, does the young person have an exam coming up, or a religious festival, so that these times should be avoided? Both young people and carers should be consulted.

Information sharing section

Antenatal information

This information may be evident in social care records or there may be the opportunity to ask parents about these details.

Risk factors for blood borne infections

The Initial health appointment is an ideal opportunity for a medical practitioner to assess whether a child has any risk factors that would indicate a need to screen for blood borne infections such as hepatitis, and HIV. Although some information will be available in health records, the health professional will need accurate and detailed information from social care to support this process. See risk factor table in Practice Note 76.

Consent

The health team that will complete the health assessment will require necessary permissions to be in place.

All required consents applying to the health assessment pathway will now be obtained and recorded on the new **referral and consent form**. Several permissions should be obtained:

- Permission for the child/young person to be invited to and have an appointment with a health professional; this appointment involves a physical examination.
- Permission from birth parents to access, record and share their health information, where it is relevant to the child's health.

The health assessment

When a child/young person enters care, social care has a statutory requirement to arrange a health assessment. The social worker should explain this duty to the young person and those with parental responsibility. CoramBAAF has produced an information leaflet that can be shared with parents to assist these conversations.

Where a young person has the capacity to make their own decision about attending the appointment, the social worker should have the conversation directly with the young person and seek their permission, which can be recorded on the form. The young person can give verbal assent.

Where the child/young person cannot make their own choice, permission can be obtained from someone with parental responsibility.

In some cases, the local authority has (or shares) parental responsibility for the child/young person. In these circumstances, submission of the referral by social care to the health team is sufficient to proceed. (In these circumstances, the social worker should still make every attempt to explain the process to parents.)

If neither of the two situations described above apply, another adult who has parental responsibility will need to give permission. The social worker should explain the statutory process to the appropriate individual. If the individual raises no objections, this can be recorded, and the referral can be submitted.

Birth parents' health information

In respect of birth parents' health information, they must give consent for this information to be obtained, viewed and shared. This needs to be recorded on the referral and consent form.

The consent section is now worded so that initial permissions from parents (if required) are relevant for the entire care episode. However, practitioners should recognise that circumstances may change in terms of the legal situation regarding parental responsibility or the child/young person's ability to take their own decisions. There may also be changes in delegated authority arrangements over time. In requesting review health assessments, social care should consider these possible changes but often will not need to seek new permissions/consent.

Health history form

Fetal Alcohol Spectrum Disorder (FASD)

Alcohol use in families can be a factor when children come into care. It is therefore recognised that statistically, care experienced people may be at higher risk of FASD.

Recognising and diagnosing FASD in children is complex. A key issue is often lack of information about an individual's likely/actual exposure to alcohol in utero. The importance of recording information about maternal alcohol consumption in pregnancy in this context is consistently raised as fundamental to meeting children's future needs.

The IHA offers a key opportunity to ensure this information is elicited and recorded. Information can be obtained directly from birth parents, recognising that this needs to be addressed with sensitivity.

Other sources of information are social care, maternity and other health records. The new IHA forms, have detailed questions included at all possible opportunities to source and record this information. For more information, see the recent article: Ascertaining risk of fetal alcohol spectrum disorder at initial health assessments for children in care (Beckett and Bond, 2024), and resources at National Organisation for FASD.

Health appointment templates

Screening tools

Note that some screening tools are produced under copyright, and that local areas adopting tools should ensure they meet the requirements around reproduction and use.

Child development

CoramBAAF does not currently recommend a specific screening tool for use during health assessments.

Children aged under five should already be accessing universal services and early years provision. However, it may be useful for practitioners to use a screening tool/approach on occasion at a health assessment appointment, e.g. for a child who has missed all previous routine screenings.

Local community paediatric pathways may determine which tools are used. In some areas there is a specific speech, language and communication screening tool in use. There are many different developmental screening and evaluation tools (e.g. Ages and stages, Global scales for early development, Schedule of Growing Skills, Griffiths, Bayley). If a child requires a comprehensive developmental evaluation, they would be referred from the health assessment to an appropriate paediatric service.

Resources

Healthy child programme schedule of interventions (Gov.UK)

Developmental Station (MRCPCH Clinical Revision)

Exploitation

Child safeguarding boards may have an agreed exploitation tool for multiagency use.

Relationships and sexual health

The health team should be aware of locally agreed pathways, resources and support for children and young people that enable them to access sexual health services. Some areas may use tools such as the Brook Traffic Light.

Emotional wellbeing and mental health

The Strengths and Difficulties Questionnaire (SDQ) is the most widely used tool in the UK, as it was introduced as a statutory requirement some years ago. Originally, the SDQ was designed involving tri-partite completion (i.e. completed by the carer, a teacher, and the child/young person). The SDQ is of most value if it has been completed in advance of a review health assessment and is available to the practitioner for reference. There are no screening tools validated specifically for use at the initial health assessment.

Substance misuse

Some areas use one of the tools originally developed in the US – the CRAFFT or Screening to Brief Intervention (S2BI) tool. The local pathway should identify whether a brief screening tool could be used in a health assessment if the practitioner feels further exploration is appropriate.

Appendix 4: List of forms and their codes

Social care teams need the following forms:

Initial health assessment

IHA-R	Referral and consent form
IHA-R-UASC	Referral and consent form for UASC
PH	Parental health
M	Maternal health information
B	Neonatal health information
P-L	Parents information leaflet print-friendly (Word)
P-L	Parents information leaflet (PDF)

Health assessment review

RHA-R	Referral for review health assessment
C-Q	Carer questionnaire
YP-Q	Young Person questionnaire
YP-Q	Child/young person questionnaire with images

Health teams need the following forms:

Initial health assessment

IHA-H	Health history form
IHA-A (0-5)	Health appointment form for children under 5 yrs
IHA-A (5-11)	Health appointment form for children 5-11yrs
IHA-A (11-18)	Health appointment form for children 11-18yrs
IHA-A (AN)	Health appointment form for children with additional needs
IHA-A (UASC)	Health appointment form for UASC
HP	Health plan

Health assessment review

RHA-A (0-5)	Health appointment review form for children under 5yrs
RHA-A (5-11)	Health appointment review form for children 5-11yrs
RHA-A (11-18)	Health appointment review form for children 11-18yrs
RHA-A (AN)	Health appointment review form for children with additional needs
HP	Health plan

Pictorial aids

My body (5-10 yrs)
Pick your smiley
My wellbeing (10 yrs+)

Abbreviations

SDQ: Strengths and difficulties questionnaire

IHA: Initial Health Assessment

RHA: Review Health Assessment

UASC: Unaccompanied asylum-seeking child

ACEs: Adverse childhood experiences