



# Medicare Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)

## Older person (55+) Health Assessment

Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed in the Explanatory Notes for the health assessment found at [www.health.gov.au/mbsonline](http://www.health.gov.au/mbsonline). The first page of this form can be used as a report of the health assessment.

Patient's Name ..... Male  Female  DOB: \_\_\_/\_\_\_/\_\_\_\_\_ or Age: \_\_\_\_\_

Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander

Work status.....

### Current contact details

Address.....

Phone.....

### Alternative contact details.....

Address.....

Phone.....

### Patient Consent

Explanation of health assessment given  Yes

Patient consent for health assessment given  Yes

Date consent was given: \_\_\_/\_\_\_/\_\_\_\_\_

### Consent given for information to be collected by

Registered Aboriginal health worker

Practice nurse

### Previous health assessment

Has the patient had a previous health assessment?

No  Yes

Date of last health assessment (if known) \_\_\_/\_\_\_/\_\_\_\_\_

Service provided by DR.....

### PATIENT'S OVERALL HEALTH

.....  
.....  
.....  
.....

### RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT

.....  
.....  
.....  
.....

### TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

TEST	AVAILABLE RESULTS & WHAT THEY MEAN

**Medicare Health Assessment for  
Aboriginal and Torres Strait Islander People**

*Older person (55+) Health Assessment*

STRATEGY FOR GOOD HEALTH: REQUIRED TREATMENT/SERVICES/HEALTH ADVICE

TREATMENT	HEALTH ADVICE	HEALTH SERVICES NEEDED

ACTION TO BE TAKEN BY PATIENT

.....

.....

.....

.....

Next appointment with doctor:..... Date: \_\_\_/\_\_\_/\_\_\_ Next Health Assessment: \_\_\_/\_\_\_/\_\_\_

GP: Dr ..... GP's Signature: ..... Date: \_\_\_/\_\_\_/\_\_\_

**MEDICAL HISTORY**

FAMILY RELATIONSHIP

Does the patient care for someone else? No  Yes

Is the patient cared for by someone else? No  Yes

CURRENT ISSUES	CURRENT RISK FACTORS

ALLERGIES/DRUG INTOLERANCE

.....

.....

.....

.....

CURRENT MEDICATIONS (including prescription and over the counter and supplied by doctor without prescription)

.....

.....

.....

.....

.....

RELEVANT FAMILY MEDICAL HISTORY

.....

.....

.....

.....

CONTINENCE

IDENTIFIED ISSUES	ACTION

IMMUNISATION STATUS - INFLUENZA, TETANUS AND PNEUMOCOCCUS (referring to current age/sex schedule)

TYPE	DATE	TYPE	DATE

ACTIVITIES OF DAILY LIFE

IDENTIFIED ISSUES	ACTION

FALLS IN THE LAST 3 MONTHS

IDENTIFIED ISSUES	ACTION

NUTRITION

IDENTIFIED ISSUES	ACTION

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

IDENTIFIED ISSUES	ACTION

HEARING LOSS

IDENTIFIED ISSUES	ACTION

COGNITION

IDENTIFIED ISSUES	ACTION

MOOD

IDENTIFIED ISSUES	ACTION

AVAILABILITY OF HELP

IDENTIFIED ISSUES	ACTION

CARING FOR ANOTHER PERSON

IDENTIFIED ISSUES	ACTION

**MEDICAL EXAMINATION**

BLOOD PRESSURE:.....  PULSE RATE AND RHYTHM: Normal  Abnormal

IDENTIFIED ISSUES	ACTION

# Medicare Health Assessment for Aboriginal and Torres Strait Islander People

## Older person (55+) Health Assessment

WEIGHT: ..... Height: ..... BMI: ..... Waist circumference (if indicated): .....

IDENTIFIED ISSUES	ACTION

GUMS AND DENTITION: Normal  Abnormal

IDENTIFIED ISSUES	ACTION

EAR AND HEARING: Otoscopy  Whisper test (if indicated)

IDENTIFIED ISSUES	ACTION

URINALYSIS

IDENTIFIED ISSUES	ACTION

TRIACHIASIS

IDENTIFIED ISSUES	ACTION

SKIN

IDENTIFIED ISSUES	ACTION

ENVIRONMENTAL AND LIVING CONDITIONS

IDENTIFIED ISSUES	ACTION

VISUAL ACUITY    Normal     Abnormal

IDENTIFIED ISSUES	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED ISSUES	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS (eg referral details)
Fasting blood sugar	<input type="checkbox"/>	Date: ___/___/_____	
Lipids	<input type="checkbox"/>	Date: ___/___/_____	
Pap Smear	<input type="checkbox"/>	Date: ___/___/_____	
STI	<input type="checkbox"/>	Date: ___/___/_____	
Mammography	<input type="checkbox"/>	Date: ___/___/_____	

Other:.....

**ASSESSMENT OF PATIENT**

(based on consideration of evidence from patient history, examination and results of any investigation)

EXISTING HEALTH ISSUES	IDENTIFIED RISK FACTORS

**INTERVENTION ACTION**

HEALTH ADVICE PROVIDED TO PATIENT

.....  
 .....

OTHER ACTION (if any)

.....  
 .....