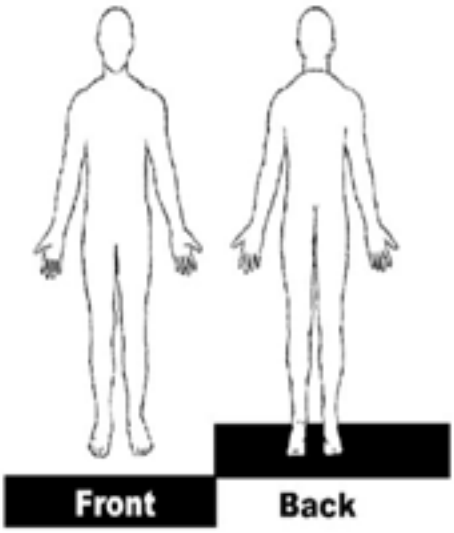
CAMHS Physical Examination – Pro Forma

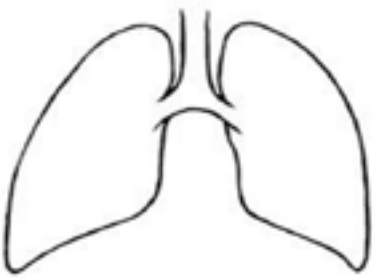
Child/Young Person's Details	
Name:	
Date of Birth:	Date of examination:
Consent, Young Person: Declined: Yes ☐ No ☐	Verbal consent obtained: Yes ☐ No ☐ If No,
Chaperone used: Yes ☐ No ☐ Chaperone Name:	(Same Gender as YP) ☐

General Survey/Vital Signs			
Type of examination (Tick type that applies)	Admission ☐	Six Monthly ☐	Other ☐
Vital Signs	BP Sit:	Pulse Sit:	RR:
	BP Stand:	Pulse Stand:	AVPU:
	Sp02:	Temp:	
Height / Weight	Height:	Waist: cm	Weight:
Allergies			
Parent/Carer Collateral (Childhood Illness / Varicella Virus History / Birth History)			
Jaundiced Yes ☐ No ☐	**Anaemia** Yes ☐ No ☐	**Cyanosed** Yes ☐ No ☐	
Oedema Yes ☐ No ☐	**Lymphedema** Yes ☐ No ☐	**Blood Sugar**	

Name: Date of Birth:

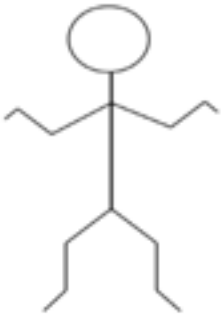
Bruising		**HEENT** (Head, Ears, Eyes, Neck, Throat/ Thyroid, Mouth)
Scar(s)		
Tattoo		
Skin Condition		

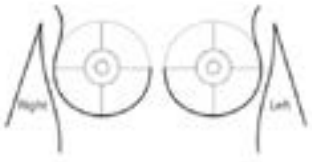
CVS		**JVP**	**Heart Sounds**
		PMI	**Note/Other**

RS		**Palpate**	**Trachea**
		Percussion	**Expansion**
		Auscultation	**Entry**

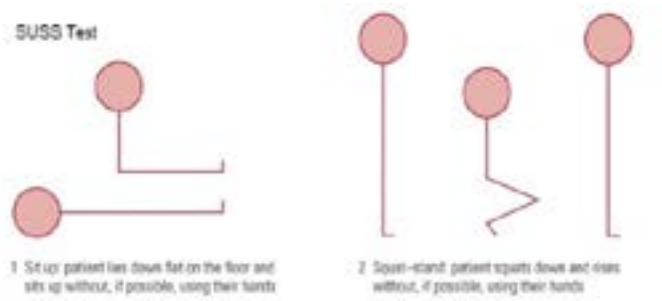
Name: Date of Birth:

GIS		**Liver**	**Sounds**
		Spleen	**Masses**
		Kidneys	

CNS		**Gait**	**Fundi / Visual Fields**
		Tremor	**Power**
		Speech	**Sensation**
		Cranial Nerves	**Tone**
		Other:	

Breast/Chest	 Evidence of Gynecomastia?	**This breast exam is only if required**

Name: Date of Birth:

Other (I.e. Vascular / MSK)	**Scoring (Separate Test 1 & 2):** 1. Able only using hands to help 2. Able: with noticeable difficulty 3. Able with no difficulty	**This breast exam is only if required** 

Urinalysis Yes ☐ No ☐ N/A ☐	**HGG** Yes ☐ No ☐ N/A ☐	**Drug Screen** Yes ☐ No ☐ N/A ☐	
ECG Yes ☐ No ☐ Not indicated ☐	**QTc**	**Rate:**	**Rhythm:**
Exercise History			
Phlebotomy	☐ Not needed (recently performed) ☐ Non-urgent (i.e. Nighttime admission – Ensure follow up) ☐ Refused / Declined – (Ensure follow up) Samples taken, and sent for: ☐ FBC, ☐ U&E's, ☐ CRP, ☐ LFT's, ☐ TFT's, ☐ Lipid profile, ☐ Haematinics, ☐ HBA1C, ☐ Prolactin, ☐ Glucose, ☐ Bi-Carb/Phosphate, ☐ Amylase & Lipase, ☐ LH/FSH/Estradiol, ☐ Testosterone ☐ Others:		

Name: Date of Birth:

Any relevant Medical History (Diabetes / Cardiovascular / Neurological):

Any relevant Family Medical History:

How would you describe your physical health?

Do you have any physical problems / physical pain?

Name: Date of Birth:

Have you lost or gained weight recently?	Yes ☐ No ☐
Was this change planned?	Yes ☐ No ☐
Please explain: (Give details of how much over what time – Complete Separate Nutritional Assessment)	

Nutritional History / Intake: (Include intake / types of food / meals over the past week)		
Any regarding: Concerns	☐ Change to appetite	☐ Swallowing
	☐ Feeling of choking on food / drinks	☐ Coughing during or after a meal
	☐ Problems chewing food	
Details: (Consider referral to SLT if concerns present)		

Name: Date of Birth:

Lifestyle Assessment (All relevant information to be included in the Young Persons Individual Care Plan (ICP)	
Diabetic Retinal Screening – (Type 1 & Type 2 diabetics 12yrs and over)	**Applicable** ☐ **/ Not Applicable** ☐
Has service user attended relevant diabetic screening programmes?	Yes ☐ No ☐
Given brief advice / brief intervention on screening programmes and made aware of the **Free-phone 1800 454 555** to check if they are on the relevant diabetic Screening Programmes' register?	Yes ☐ No ☐

GP / Dental / Optical Assessment			
General Practitioner Contact: Please tick	**Regular** ☐	**Infrequent** ☐	**Rarely** ☐
Dental Practitioner Contact: Please tick	**Regular** ☐	**Infrequent** ☐	**Rarely** ☐
Does service user have any dental problem(s)?	Yes ☐ No ☐	Declined ☐	Unable to Answer ☐
Does service user have problems with eyesight?	Yes ☐ No ☐	Declined ☐	Unable to Answer ☐
Does young person have any problems with hearing?	Yes ☐ No ☐	Declined ☐	Unable to Answer ☐
Follow up required? (Please include in Young Person's ICP)			

Sexual Health & Sleep Patterns	
Sexual Health	
Is young person sexually active?	Yes ☐ No ☐
Is young person or could they be pregnant? If yes, consider referral to Perinatal Mental Health Services.	Yes ☐ No ☐
Do they have any concerns in relation to their sexual health? (If required and if clinically appropriate please commence referral to sexual health services as available)	Yes ☐ No ☐
Given brief advice / brief intervention on safer sex and/or contraceptive practices	☐

Name: Date of Birth:

Sleep
Does service user have any problems with sleep? Yes ☐ No ☐ Declined / Unable to Answer ☐ If Yes Give Details:
How many hours does young person usually sleep at night?
Does Service User take sleeping aids? Yes ☐ No ☐ If yes, please give details
Given brief advice / brief intervention on sleep hygiene ☐

Tobacco/Vaping use
Does young person SMOKE/VAPE any products? Never ☐ Daily ☐ Prescribed / Referred for (NRT/Varenicline) ☐ *Signposted to HSE Tobacco cessation services /QUIT service (helpline 1800 201 203 and www.quit.ie)*

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Alcohol / Drug Use	*Consider Child Protection Implications
1. **How OFTEN do you have a drink containing alcohol?** 0= Never 1= Monthly or less 2= 2-4 times a month 3= 2-3 times a week 4= 4 or more times a week	
How many times in the past year have you used street, over the counter or prescription drugs for Non-medical reasons? (List names / type / quantities / situations / last intake / effects / withdrawal symptoms)	
Comments: (Other physical health issues identified)	

Key Findings of Physical Examination	
Feedback given to Young Person	Yes ☐ No ☐
Feedback given to Parent/Guardian	Yes ☐ No ☐

Further Investigations Required / Follow Up Required	
Completed by:	**Signature:**
MCRN / NMBI Pin:	**Date:**
Date:	