Australian Government
Department of Health

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.

Patient's Name ..... Male ☐ Female ☐ DOB: / /____or Age:___

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Works status .....

Current contact details
Address .....
Phone .....

Alternative contact details .....
Address .....
Phone .....

Patient Consent
Explanation of health check given Yes ☐
Patient consent for health check given Yes ☐
Date consent was given: __/__/____

Consent given for information to be collected by:
Aboriginal and Torres Strait Islander health practitioner ☐
Practice nurse ☐
Other suitably qualified health professional ☐

Previous health assessment
Has the patient had a previous health assessment?
Yes ☐ No ☐

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 AND WHAT THEY MEAN

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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: Date: / /____
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 a doctor without prescription)

……
……
……

RELEVENT 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

VISUAL ACUITY (ask about clarity and comfort of vision at distance and near)

IDENTIFIED ISSUES	ACTION

COGNITION

IDENTIFIED ISSUES	ACTION

MOOD

IDENTIFIED ISSUES	ACTION

AVAILABILITY OF HELP

IDENTIFIED ISSUES	ACTION

CARING FOR ANOTHER PERSON

IDENTIFIED ISSUES	ACTION

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MEDICAL EXAMINATION

BLOOD PRESSURE: …… ☐ PULSE RATE AND RHYTHM: Normal ☐ Abnormal ☐

IDENTIFIED ISSUES	ACTION

WEIGHT: …….. HEIGHT: …….. BMI: …….. Weight circumference (if indicated): ……..

IDENTIFIED ISSUES	ACTION

GUMS AND DENTITION: Normal ☐ Abnormal ☐

	ACTION

EAR AND HEARING: Otoscopy ☐ Whisper test (if indicated) ☐

IDENTIFIED ISSUES	ACTION

URINALYSIS ☐

IDENTIFIED ISSUES	ACTION

TRICHIASIS ☐ (Note: Examine those people who have grown up in remote communities or have a history of 'sore or watery eye')

IDENTIFIED ISSUES	ACTION

SKIN ☐

IDENTIFIED ISSUES	ACTION

ENVIRONMENTAL AND LIVING CONDITIONS ☐

IDENTIFIED ISSUES	ACTION

VISUAL ACUITY Normal ☐ Abnormal ☐ (Test near and distance visual acuity)

IDENTIFIED ISSUES	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED PROBLEMS	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS(eg referral details)
Fasting blood sugar	☐	Date /__/_____	
Lipids	☐	Date /__/_____	
Pap Smear	☐	Date /__/_____	
STI	☐	Date /__/_____	
Mammography	☐	Date /__/_____	
Optometry	☐	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)
……
……