**Patient Name or initials: DOB: Date and Time of conference:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Conference participants:** *Consider inviting: patient, parent, carer, Child Safety Officer, allied health, Paediatrician, Aboriginal Health Service/Cultural Advisor, mental health clinician, school, Foster & Kinship/Residential agency worker. Indicate name, service and role.* | | | |
|  |  |  |  |
|  |  |  |  |
| **Other services involved:** |  |  |  |

|  |  |
| --- | --- |
| **Previous assessments, diagnoses, allergies or medial history** (include dates): | **Personal information about the child/young person:** *Consider positive aspects, interests, things that are important to them, progress.* |
| <autopopulate>  Health Assessment attached |  |
| **Current Medication:** Consider ‘over-the-counter’ and ‘natural’ drugs and supplements | **Goals of the child/young person, family, carer:** |
| <autopopulate> |  |

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| --- |
| **Progress since previous case conference (if applicable):** *previously identified actions and progress* |
|  |

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| --- | --- | --- | --- |
| **Important issues and concerns** | **Actions:** | **Who:** *GP, parent, carer, allied health, specialist, school* | **Timeframe:** |
| *Medication:* |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Immunisation:* |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Physical concerns/disability:*  Dental:  Hearing:  Vision:  Physical activity: |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Mental Health/behavioural:*  Sleep: |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Learning/Education and other developmental:* |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Cultural connectedness:* |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Other:* |  |  |  |
| Completed  *[Document any barriers to completion here]* |
| *Ongoing needs over 12 month period:* |  |  |  |

**Verbal agreement to Health Management Plan by parent/carer/Child Safety Officer.**

**Duration of case conference: Doctor in Attendance:**   **Signature:**