NEPCP Partnership For Healthy Communities

Hume Whittlesea Primary Care Partnership

Physical Health Screening Tool

Name: ___________________________________ Date: ________________

	Please respond to the following by ticking those statements that apply to you and any items you would like to discuss further:	(√)	I would like to discuss (√)
1	I have been told by a doctor or other health professional that I have a health condition (arthritis, high blood pressure, diabetes, heart disease, a cancer, osteoporosis, asthma, lung disease, chronic kidney disease or other condition)		
2	I have had a GP check up in the last 6 months which included blood tests and a blood pressure check.		
3	I have had a pap smear in the past 2 years (for women)		
4	I have had a mammogram in the last 2 years (for women over 40 years old)		
5	I have had a prostate check in the last 12 months (for men over 50 years old)		
6	I would like a sexual health consultation (contraception, family planning, STIs)		
7	I am concerned about my medications		
8	I have recently had problems with my vision		
9	I have recently had problems with my hearing		
10	I have recently had problems with my teeth, mouth, gums or dentures		
11	I am concerned about my weight		
12	I have recently lost weight without trying		
13	I am concerned about my diet		
14	I am concerned about my lack of physical activity		
15	I have difficulties with my balance		
16	I have difficulty with daily tasks (getting dressed, showering)		
17	I currently smoke tobacco		
18	I am concerned about how much alcohol I drink		
19	I am concerned about my use of drugs		
20	I am concerned about my gambling		
21	I have trouble managing my finances		
22	I often feel sad or depressed		
23	I often feel nervous or anxious		
24	I have felt afraid of someone who controls or hurts me		
25	I am homeless or at risk of homelessness		

Developed by the *Physical Health Matters Too Project Steering Committee*, with support from the Victorian Department of Health under the Community Mental Health Planning and Service Coordination Initiative

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Name: ____________________________________ Date: _________________

Summary table of referral pathways. Refer to **Service Information- Referral Pathways for Consumers** document for more details regarding individual services and contact details.

Question(s)	Referral to
1. Chronic Condition	GP or Chronic Disease Program
2. GP Check Up	GP
3. Pap Smear	GP
4. Mammogram	Breastscreen Victoria or GP
5. Prostate	GP
6. Sexual health	GP or Community Health Nurse
7. Medications	GP
8. Vision	GP or Optometrist
9. Hearing	GP or Audiologist
10. Oral Health	Dental Program
11-13. Nutrition	Dietitian
14-15. Physical Activity & Balance	Physiotherapist
16. Daily Tasks	Occupational Therapist
17. Tobacco	Quit or Smoking Cessation Program
18-19. Alcohol and Drugs	Alcohol and Drug Counsellor
20. Gambling	Gambling Counsellor
21. Finances	Financial Counsellor
22-23. Anxiety and Depression	General Counsellor
24. Family Violence	Family Violence Program
25. Housing	Housing Service

Referral Action Plan

Taking into account any issues you and the consumer have subsequently identified, summarise the action required.

Date Referral Sent	Agency	Service Type	Phone Number	Purpose of Referral	Consumer Consent	Referral Method	Feedback to

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