









LD Nurse:



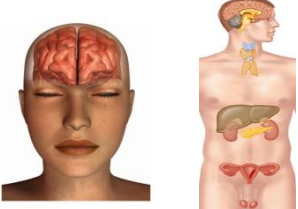


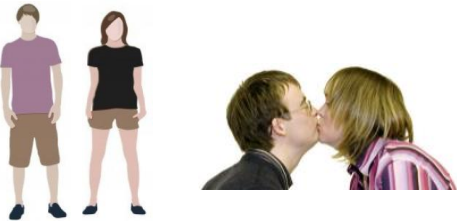

Tel: 0121 543 4287

NHS No:

## ANNUAL HEALTH CHECK ACTION PLAN

Black Country Partnership   
NHS Foundation TrustName: Date: GP: 

<b>Lifestyles</b> 	<b>Body Mass Index</b> <input type="text"/> <b>Weight</b> <input type="text"/> <b>kgs</b> <input type="text"/> <b>Height</b> <input type="text"/> <b>cms</b> <input type="text"/> <b>Action:</b>
<b>Blood Test and Immunisation</b> 	<b>Blood Test:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Flu Vaccine:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood test results:</b>
<b>Vision</b> 	<b>12 monthly eye test:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Action:</b>
<b>Hearing</b> 	<b>Ears examined:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Action:</b>
<b>Oral Health</b> 	<b>6 monthly check:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Action:</b>
<b>Circulation</b> 	<b>Blood Pressure</b> <input type="text"/> <input type="text"/> <b>Pulse</b> <input type="text"/> <b>Action:</b>
<b>Breathing</b> 	<b>Diagnosed respiratory condition</b> <input type="text"/> <b>Action:</b>
<b>Digestion/Abdomen</b> 	<b>Abdominal Aortic Aneurysm screen</b> <input type="checkbox"/> (men 65 yrs and over) <b>Action:</b>

<p><b>Bowels &amp; Bladder</b></p> 	<p>Bowel Screening (60-69 yrs) <input type="checkbox"/> Urinalysis <input type="checkbox"/>          Bowel Scope (55 yrs) <input type="checkbox"/>          Review of constipation/medication (if applicable) <input type="checkbox"/>          Action:</p>
<p><b>Mental Health/Behaviour</b></p> 	<p><b>Mental Health Diagnosis</b> <input type="text"/>          Action:</p>
<p><b>Neurology /Endocrine</b></p> 	<p><b>Diagnosed condition:</b> <input type="text"/>          Action :</p>
<p><b>Mobility and Foot Health</b></p> 	<p><b>Postural Care Needs:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  <b>Chiropodist</b> Yes <input type="checkbox"/> No <input type="checkbox"/>          Action:</p>
<p><b>Skin, Hair and Nails</b></p> 	<p><b>Diagnosed Skin Condition:</b> <input type="text"/>          Action:</p>
<p><b>Men's/Women's Health</b></p> 	<p>Mammography (47-73 yrs) <input type="checkbox"/> Cervical Screen (25-64 yrs) <input type="checkbox"/>          Testicular Check <input type="checkbox"/> Sexual health <input type="checkbox"/>          Action:</p>
<p><b>Medication</b></p> 	<p>Action:</p>

Action Plan	Who will action?

