**Childhood obesity: additional assessment (social and medical)**

Always consider the potential of [neglect](https://www.proceduresonline.com/nesubregion/p_neglect.html) when assessing obesity

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of child:** | |  | |  | **DOB:** |  | | |  | **BMI =** [weight/height2] |  |
|  | | |  |  |  | | |  |  |  |  |
| **School:** |  | | |  | **NHS no:** | |  | |  | **Centile =** |  |

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| **Date of assessment:** |  |  | **Name of GP:** |  |  | **GP Practice:** |  |

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|  | | | | | | | | **YES** | **NO** | | **COMMENTS** | | |
| 1. Is the child currently engaged with Children’s Services or any other Services (e.g. CYPS, Early Help) | | | | | | | |  |  | |  | | |
| 1. Is the child severely obese (BMI on or above 99.6th centile)? *Attach centile chart to show BMI trajectory if available* | | | | | | | |  |  | |  | | |
| 1. Has the child had some weight management advice including a weight management plan? | | | | | | | |  |  | |  | | |
| 1. Has the child made any progress with weight management advice? | | | | | | | |  |  | |  | | |
| 1. Are there any other Child Safeguarding Concerns? (incl. other indicators of abuse/neglect) | | | | | | | |  |  | |  | | |
| 1. Has a medical professional informed the family of the significance of their child's weight and the health risks involved? | | | | | | | |  |  | |  | | |
| 1. Do parents/carers understand the concerns around their child’s weight? Please specify any barriers. | | | | | | | |  |  | |  | | |
| 1. Do the parents/carers appear willing to engage with support? | | | | | | | |  |  | |  | | |
| 1. Are there any barriers to the parents/carers engaging with weight management? If yes, please specify in comments. | | | | | | | |  |  | |  | | |
| 1. Does the child understand the concerns around their weight? Comment on age as appropriate. | | | | | | | |  |  | |  | | |
| 1. Is the child willing to engage? Comment on age as appropriate. | | | | | | | |  |  | |  | | |
| 1. Are the concerns escalating over time? | | | | | | | |  |  | |  | | |
|  | | | | | | | |  |  | |  | | |
| **What is the impact of obesity on the child’s health and wellbeing?**  10 = appropriate lifestyle and 0 = severely impacted & will lead to serious harm or death (please *circle or highlight)* | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | | | 2 | | 1 | 0 |

# Child Health Factors

Please tick or highlight all physical/emotional problems that apply:

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| --- |
| Is there a diagnosis of any health conditions? |
|  |
| Is the child on any medication? |
|  |
| Further comments: |
|  |

|  |  |
| --- | --- |
| Physical problems | Emotional problems |
| Joint pain/problems | Low self-esteem |
| Difficulties with self-care | Loneliness or isolation |
| Hygiene | Sadness or depression |
| Appearance, ill-fitting clothes | Worry, fear or anxiety |
| Unable to walk to/from school | Trigger (eg bereavement, accident, separation) |
| Enuresis/incontinence | Anger/frustration |
| Constipation/diarrhoea | Teasing/bullying/social discrimination |
| Shortness of breath | Reclusive/ uncomfortable to go out |
| Sleep apnoea/snoring |
| Type II Diabetes |
| High BP |
| High cholesterol |
| Asthma |

# Parenting & Family Factors

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| --- | --- | --- | --- |
|  | **YES** | **NO** | **COMMENTS** |
| 1. Are parents or siblings obese/overweight? |  |  |  |
| 1. Absence of meal routines/ meals unplanned? |  |  |  |
| 1. Are parents/carers unsure of what child is eating? |  |  |  |
| 1. Does the parent see any of the above as a problem? |  |  |  |
| 1. Does the child have a LAC/CPP/CIN/Early Help plan? If so, name of social/support worker. |  |  |  |
| 1. Does parent believe that the child’s weight is a problem? |  |  |  |
| 1. Does parent enable child to attend health appointments? |  |  |  |
| 1. Does parent accept health advice? & comply with treatment? |  |  |  |

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| **Form completed by:** |  |  | **Date of completion:** |  |

## Please indicate if you have discussed this case with any of the following?

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Early Help |  |  |
| Safeguarding team at QEH |  |  |
| Integrated Referral Team (Children’s social care) |  |  |
| 0-19 service |  |  |
| QEH Paediatrics |  |  |
| Other |  |  |
| Comments: | | |

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| --- | --- | --- |
| **Main concerns identified** | **Plan of action (inc staff responsible)** | **Expected Outcome & Timescale** |
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| --- |
| Evidence of the child’s wishes and feelings (include the child’s view of their weight/obesity): |
|  |

|  |  |
| --- | --- |
| **Date of consent for information sharing given (if necessary):** |  |
|  |  |
| **Date of multi-agency discussion**  **(if this has taken place):** |  |
|  |  |
| **Date of next review:** |  |

|  |  |
| --- | --- |
| Signed: |  |
|  |  |
| Role: |  |