Appendix 2 A

Health Form 1 Assessment

Name: Age:		Date last screen performed	
Height Weight Measurement	Annually		
Clinical breast/testicular exam	Annually		
Cancer Screening		Date	Y/N
Mammography/ ultrasound (Women)	Every 1-2 years after age 40, at discretion of physician/patient. Earlier if family history Ultrasound may be used as an alternative breast cancer screening/procedure		☐☐
Pap Smear (Women)	Every 1-3 years after age 19. May be omitted after age 65 if previous screening were consistently normal.		☐☐
Prostate cancer screen	Per MD recommendation after age 50.		☐☐
Skin cancer screen	Per MD recommendation.		☐☐
Colorectal Cancer Screening			
Colonoscopy	Every 10 years after age 50, per MD recommendation or if above screen not performed		☐☐
Sigmoidoscopy	Every 5 years after age 50.		☐☐
Fecal Occult Blood Testing	Annually after age 50.		☐☐
Other Recommended Screening			
Hypertension	Annually		☐☐
Cholesterol	Every 5 years at physician discretion.		☐☐
Diabetes (Type II)	Fasting plasma glucose screen for individuals at high risk. At least every 5 years until age 45. Every 3 years after age 45.		☐☐
Liver Function	Test annually for Hepatitis B carriers.		☐☐
Osteoporosis	Bone density screening per risk factors of general population.. Additional risk factors include medications, mobility impairment, hypothyroid.		☐☐
Infectious Disease Screening			
Chlamydia and STDs	Annually, if at risk.		☐☐
HIV	Periodic testing if at risk.		☐☐
Hepatitis B and C	Periodic testing if at risk. Every 3 years as recommended by physician.		☐☐
Tuberculosis	Skin testing every 1-2 years for individuals at risk.		☐☐

Health Form 1 Assessment

Sensory Screening		Date	Y/N
Hearing Assessment	**Screen** annually. Re-evaluate if hearing problem is reported or a change in behavior is noted.		☐☐
Vision Assessment	**Screen** annually. Re-evaluate if vision problems are reported or change in behavior is noted		☐☐
Glaucoma	Every 3-5 years in high risk patients. At least once in patients with no risk factors.		☐☐
Mental and Behavioral Health			
Depression	Screen annually for sleep, appetite disturbance, weight loss, general agitation For more information about depression and to complete the CES-D NMIH Depression Scale, please click the following link: http://www.chcr.brown.edu/pcoc/cesdscale.pdf		☐☐
Dementia	Monitor for problems performing daily activities. In persons with Down Syndrome, annual screen after age 40. For more information about Dementia and to complete a Dementia Screening Questionnaire, please visit the following website: http://www.ld-medication.bham.ac.uk/questionnaire.pdf		☐☐

Immunizations *Please see the Health Passport for Immunization Information*

Down Syndrome			
Thyroid Function	Every 3 years (sensitive TSH)		☐☐
Cervical Spine x-ray to rule out atlanto-axial instability	Obtain baseline as adult. Recommend repeat if symptomatic, or 30 years from baseline.		☐☐
Echocardiogram	Obtain baseline if no records of cardiac function are available.		☐☐
Other Screening to be considered:			

Note: Some individuals require a different schedule of screening based on family history, age, or the presence of other health conditions. If the screening is not completed or deferred, the RN or MD should initial this form and provide a full explanation in the progress note. For example, if a colonoscopy has been deferred, the entry should be initialed by the MD or RN with the following notation: "Deferred, see progress note dated_____."

All results must be reviewed by the individual's Primary Care Provider

Appendix 2B

HEALTH FORM 2 DIRECT OBSERVATION

BACKGROUND: Establishing a set of routine/preventive health care recommendations is only one step in assuring that individuals receive quality health care. The ability of a health care provider to do quality assessments, diagnosis and treatment, in large part, rests on the quality of the history and information that he/she receives. In the general population, information regarding health care status is usually communicated by the patient or a family member. While many people with mental retardation may be able to share information with a health care provider, others are largely dependent upon the observations of direct support professionals to record and report information. It is critical, therefore, that MRDDA providers have a consistent manner in which to gather information regarding health issues and changes to better inform the primary health care provider. Without this critical information, it is doubtful that a full review can be successfully accomplished. The Direct Observation form helps to provide consistent, relevant and thorough health status information to the treating provider at the time of the medical encounter.

PURPOSE: The Direct Observation form is generally completed by direct support professionals. The tool asks direct support professionals who interact most directly with individuals on a day-to-day basis to respond to questions about easily observable indicators of health or illness. It does not require that staff make any clinical judgments, only that they observe and record what they see.

The Direct Observation form is required to be used in preparation for the Health Management Care Plan and is recommended for any visit to the individual's primary care provider. It is not required for use in preparation for specialty visits, unless the provider feels such use would be helpful. This checklist can also be used at regular intervals to monitor specific conditions or to note changes in health status.

While the checklist was developed primarily with the direct support professional in mind it can also be used by family members or other provider staff to help prepare for a consultation or visit with a health care provider. Consistent use of this form by direct support professionals can also assist staff to be more attuned to issues of concern and help them to become better observers of potential signs and symptoms of illness It can also serve as historical information for new staff to have a better understanding of an individual's previous health status.

Appendix 2B-Health Form 2 Direct Observation

Health Status Indicators **Highlight or circle changes in health status. Any "Yes", "Don't know" or "Recent Change" may indicate a need for monitoring.	Yes	No	Don't know	Check if recent change
HABITS: Does this person: 1. Smoke or use tobacco products? 2. Drink alcohol? 3. Avoid regular exercise? 4. Engage in sex? 5. Engage in substance abuse?				
SLEEP: Does this person: 1. Have problems sleeping at night? 2. Get up 2 or more times during the night to go to the bathroom? 3. Fall asleep during the day?				
EATING/WEIGHT: Has this person: 1. Gained or lost more than 10 pounds in the past year? 2. Ever choked while eating? 3. Had trouble chewing or swallowing? 4. Cough or had a change in their breathing during or after eating or drinking? 5. Ever been reluctant to eat or drink? 6. Needed to change the texture of their food or drink?				
CARDIAC: Does this person: 1. Ever complain of chest, jaw or left arm pain? 2. Have swollen feet or ankles? 3. Ever have blue lips or nails?				
RESPIRATORY: Does this person: 1. Frequently cough or wheeze? 2. Have shortness of breath when at rest? 3. Have shortness of breath while exercising? 4. Have frequent colds, pneumonia, sinus infections or bronchitis?				
GASTROINTESTINAL: Does this person: 1. Complain of or appear to have heartburn: rub chest, or burp frequently? 2. Vomit 2 or more times per week? 3. Complain of or appear to have abdominal pain? 4. Have a bowel movement less than 3 times per week? 5. Frequently have 3 or more bowel movements per day? 6. Seem to have difficulty moving their bowels? 7. Ever have blood in their bowel movements?				

Appendix 2B-Health Form 2 Direct Observation

	Yes	No	Don't know	Check if recent change
NEUROLOGICAL: Does this person: 1. Have a seizure disorder? 2. Complain of headaches, loss of consciousness, or dizziness? 3. Fall a lot or have difficulty with balance? 4. Walk differently lately? 5. Show a change in what their seizures look like?				
SKIN & NAILS: Does this person: 1. Have dry skin? 2. Have any rashes, redness or open sores on their skin? 3. Have any unusual lumps or bumps on or under the skin? 4. Have any unusual marks or moles on the skin? 5. Have problems with fingernails or toenails? 6. Have any blisters or calluses on their feet?				
MOUTH: Does this person: 1. Have gums that bleed while brushing their teeth? 2. Have any sores in their mouth? 3. Grind their teeth? 4. Have bad breath? 5. Have swollen gums?				
VISION/ HEARING: Does this person: 1. Ever have redness or drainage from their eyes? 2. Rub their eyes? 3. Squint? 4. Ever have drainage from their ears or earwax problems? 5. Respond to sound differently lately? 6. Wear a hearing aid or glasses?				
MOBILITY: Does this person: 1. Have trouble using stairs? 2. Have trouble getting around the house? 3. Have difficulty standing, sitting, or bending?				
MUSCULOSKELETAL: Does this person: 1. Complain of or appear to have joint or muscle pain or stiffness? 2. Have a history of broken bones or osteoporosis (brittle bones)? 3. Have any deformities of the feet? 4. Wear special shoes?				

	Yes	No	Don't know	Check if recent change
GENITOURINARY: Does this person: 1. Have trouble starting to urinate? 2. Complain of pain or burning during or after urinating? 3. Have urine that has an unusual color or bad odor? 4. Have frequent bladder or kidney infections? 5. Menstruate (have a period)? 6. Experience pain or other behavior changes during their period (menstruation)? 7. Report a change in their menstrual cycle? 8. Ever have any unusual vaginal bleeding or discharge? 9. Ever bleed or have unusual discharge from their penis? 10. Have any lumps or report pain in their groin?				
BEHAVIOR: Currently, does this person ever: 1. Hurt him/her or others? 2. Damage property? 3. Appear unusually sad or depressed? 4. Withdraw from others? 5. Display moodiness or irritability? 6. Eat nonfood items? 7. Complain of pain? 8. Have any recent history of personal losses or major life stressors? 9. Display sexually inappropriate behavior? 10. Run or wander away? 11. Appear anxious (nervous, agitated, or restless)? 12. Appear forgetful? 13. Repeat words and/or actions again and again?				

Appendix 2C

HEALTH FORM 3 DIAGNOSTIC REVIEW

BACKGROUND: Some people with intellectual disabilities have complex medical conditions and varying levels of ability to manage their own health services. It is critical to include a step to coordinate that status of all health factors and interventions.

PURPOSE: An annual physical, health screening recommendations, and direct observations are important steps for assuring that those individuals receive quality health care. Reviewing medical records, records of specific interventions, and medication records is another important step for quality health care. The Diagnostic Review is designed to provide an instrument to organize a systematic review of an individual's current assessments, physical exam, specialists' reports, and medical interventions in a systematic way.

The Diagnostic Review is organized by body system so that it can be cross referenced to the Health Management Care Plan and provides a comprehensive review of all diagnoses, interventions, intervention documentation, risk factors, and screening recommendations. The diagnostic review provides data that can be used to develop a comprehensive Health Management Care Plan that addresses those health factors.

A nurse or other licensed health professional conducts the Diagnostic Review. The Diagnostic Review is developed from a review process that includes reviews of:

- Annual physical
- Health Form 1 Assessment
- Health Form 2 Direct Observation
- All current procedures and interventions in the medical chart
- Medication records
- Records of medical appointments
- All other relevant medical information

Health Form 3 Diagnostic Review

Name: DOB: Date of Review:						
Address: City, State, Zip Home Phone Number:						
Weight: Height: Sex: M F Race: Hair: Eye: Blood Type:						
Name of Evaluator: Signature:						
Health Risk Factors	**Yes**	**No**	**If yes, Stable?**	**If yes, Unstable?**	**Screening Recommended**	**Documentation Incomplete**
Cardiovascular Hypertension Coronary Artery Disease Congestive Heart Failure Heart Murmur Mitral Valve Prolapse Cardiac Arrhythmia Pacemaker Angina Deep Vein Thrombosis Recent Stroke Hx of MI Other						
Endocrine Diabetes Pituitary Disease Thyroid Disease Cancer Other						
Infectious Disease Chronic Hepatitis B Hepatitis C HIV/AIDS Tuberculosis under Rx STD Other						
Pulmonary Asthma Bronchitis COPD Cancer Other						

Appendix 2C-Health Form 3 Diagnostic Review

Health Risk Factors	Yes	No	If yes, Stable?	If yes, Unstable?	Screening Recommended	Documentation Incomplete
Neurology						
Seizure disorder						
Dementia (any cause)						
Ataxia						
Cancer						
Other						
Psychiatry						
Axis 1 Diagnosis						
Extra pyramidal Disorder						
Other						
Autoimmune						
Lupus						
Sarcoidosis						
Rheumatoid Arthritis						
Other						
Gastrointestinal						
Peptic ulcer disease						
G.E.R.D.						
Cancer						
G.I. Incontinence						
G.I. Dysmotitlity (upper or lower)						
G Tube						
Liver Disease						
Chronic Constipation						
Other						
Nutritional						
Obesity						
Morbid obesity						
Hypercholesteremia						
Unexplained weight loss						
Underweight						
Metabolic disorder						
Other						

Appendix 2C-Health Form 3 Diagnostic Review

Health Risk Factors	Yes	No	If yes, Stable?	If yes, Unstable?	Screening Recommended	Documentation Incomplete
Hematological Anemia Bone marrow depression Leukemia Sickle cell anemia Other						
Skin Burn wound Chronic wound (Non pressure related) Pressure sore Cancer Other						
Musculoskeletal / Extremities Paresis Paraplegia Muscular dystrophy Osteoarthritis Osteoporosis Fractures Amputation Cancer Other						
Gynecological Vaginal cancer Cervical cancer Uterine cancer Uterine Fibroids Other						

Appendix 2C-Health Form 3 Diagnostic Review

Health Risk Factors	Yes	No	If yes, Stable?	If yes, Unstable?	Screening Recommended	Documentation Incomplete
Urological Prostate cancer Prostate enlargement Incontinence Renal failure Indwelling catheter Renal failure Renal cancer Other						
Habits Alcohol Use/abuse Tobacco Illegal drugs Other						
Behavior Assaultive Self-Injurious Pica Darting/Running Other						
Other Risk Factors Sleep disorder Feeding/Eating/Swallowing Concerns Falls Frequent hospitalization Genetic syndromes Frequent hospitalization Unexplained Pain Frequent headaches Other						