

Annual Health Check

This form relates to the Healthcare Policy

ANNUAL HEALTH CHECK FOR A PERSON WITH AN INTELLECTUAL DISABILITY

Date:	NHI Number:
Patient Name:	
Marital Status:	Sex:
Principal Carer (e.g. IDEA Services, Parent):	
Age:	Ethnic Origin:
Accompanying Support Person:	
Patient's Address:	
Parent's Address:	

ALERTS

Weight (kg): Height (cm):

Blood Pressure: Urine Analysis:

Respiration:

Baseline Temperature:

Pulse:

Cigarettes (per day): History of smoking Yes No

Alcohol (units per week):

Teeth / Dentures Requiring Attention: Yes No

IMMUNISATIONS

People with intellectual disability should have the same regimes as others and the same contraindications apply.

Tetanus in last ten years	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
If 'No' has tetanus been given	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Immune	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Other (specify):		

PHYSICAL OVERVIEW

General Appearance:

Anaemia:

Lymph Nodes:

Clubbing (fingers):

Jaundice:

Hydration:

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Nutrition:

Enteral Feeding:

Other:

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CHRONIC ILLNESSES

Does your patient suffer any chronic or life-threatening illnesses?

Diabetes Yes No Comment:

Annual Diabetes check Yes No Comment:

Retinopathy check Yes No Comment:

Respiratory Yes No Comment:

Hepatitis Yes No Type?

Comment:

Musculo-skeletal Yes No Comment:

Bone density check Yes No Comment:

Gastric Yes No Comment:

Cardiac Yes No Comment:

Cancer Yes No Comment:

Other (Arthritis, Osteo etc.):

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Systems Enquiries

Reproductive

WOMEN'S HEALTH

Last Known Menstrual Period:

Dysmenorrhoea Yes No

Inter-menstrual bleeding Yes No

PV discharge Yes No

Oral Contraceptives Yes No

Since date:

IM Contraception Yes No

Since date:

Surgical Sterilisation / Hysterectomy Yes No Date:

Menopausal Yes No

Other:

CERVICAL SCREEN

Is a smear indicated? Yes No

If 'Yes', when was last smear?

What was the result?

What actions occurred / is indicated?

When is next smear due?

BREAST EXAMINATION

Any Lumps Yes No

Nipple Retraction Yes No

Discharge Yes No

Skin Changes Yes No

MAMMOGRAPHY

Is there anything in family history which would suggest a need for earlier mammography? Yes No

Has mammogram been performed? Yes No Date:

MEN'S HEALTH

Is there anything in family history
which would suggest a need for
earlier examination?

Yes No

Testicular Examination

Yes No

Prostate Examination Indicated?

Yes No

PSA Level

Yes No

Since date:

GENITO URINARY

Dysuria

Yes No

Frequency

Yes No

Haematuria

Yes No

Urinary Incontinence

Yes No

If 'Yes' has M.S.U. been done?

Yes No

Would you consider other
investigations?

Yes No

Comments:

DERMATOLOGY

Fungal Infections

Yes No

Eczema / dermatitis

Yes No

Skin / moles checked

Yes No

Any Abnormality

Yes No

Comments:

RESPIRATORY

Abnormal Breath Sounds

Yes No

Cough

Yes No

Haemoptysis

Yes No

Sputum

Yes No

Wheeze

Yes No

Dyspnoea

Yes No

Comments:

CARDIO VASCULAR

- Chest Pain Yes No
Swelling of Ankles Yes No
Palpitations Yes No
Peripheral Nerve Damage Yes No
Cyanosis Yes No

Heart Sounds:.....

Comments:

GASTRO-INTESTINAL

- Masses Yes No
Liver function test required Yes No
Constipation Yes No
Diarrhoea Yes No
Weight Loss Yes No
Dyspepsia Yes No
Reflux Yes No
Melaena Yes No
Rectal Bleeding Yes No
Faecal Incontinence Yes No
Rectal Examination completed Yes No
Helico-bacter Pylori test Yes No

Has person previously lived:

in an institution? Yes No

Dysphagia / choking Yes No

Referral to Speech Language Yes No

Therapist required

Further Examination indicated Comments:

Comments:

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MUSCULO-SKELETAL

Prompt: Many people with intellectual disabilities have cerebral palsy and other neuro-muscular disorders

- | | | |
|--------------------------|------------------------------|-----------------------------|
| Loss of movement | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Postural problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weakness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skeletal anomalies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Joint anomalies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscle anomalies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoporosis Prophylaxis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments:

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MOBILITY

- | | | | |
|-----------------------------|------------------------------|-----------------------------|-------------|
| Patient is Fully Mobile | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Patient is Mobile with Aids | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Patient is Immobile | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Recent Specialist Review | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date: |

Name of Mobility Specialist:

Further investigations / interventions indicated?

Comments:

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CENTRAL NERVOUS

Prompt: People with an intellectual disability are particularly prone to abnormalities in vision, hearing, mobility and communication - a change in function may reflect CNS changes and indicate further investigation.

LOCALISED SYMPTOMS

- | | | |
|--------------|------------------------------|-----------------------------|
| Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Faints | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Paraesthesia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weakness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments:

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VISION

Is the support person concerned? Yes No

Normal Vision Yes No

Minor Visual Problem Yes No

Major Problem Yes No

Does patient wear glasses? Yes No

When did Patient last see an Optometrist?

Result of Snellen Chart:

Comments:

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HEARING

Is the support person concerned? Yes No

Normal Hearing Yes No

Minor Hearing Problem Yes No

Major Problem Yes No

Does He / She Wear a Hearing Aid Yes No

Any Wax Yes No

Recent Audiologist review Yes No Date:

Other Investigation:

Comments:

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COMMUNICATION

Does Patient Communicate Normally Yes No

Does Patient Communicate with Aids Yes No

Does Patient have Severe Communication Problem Yes No

Does Patient see a Speech Therapist Yes No

Comments:

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EPILEPSY

Yes No

If yes, type of seizure:

Does documentation of seizures appear adequate (Refer recordings in Blue Medication Folder):

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If seizure free, when was the last known seizure:

Frequency of seizures:

Daily

Weekly

Monthly

Yearly

Are the seizures

Increasing Yes No

The same Yes No

Improved Yes No

Antiepileptic medication prescribed Yes No

Post seizure medication prescribed Yes No

Blood levels tested Yes No

Requires Specialist referral Yes No

Has seen Specialist / Neurologist Yes No

Name of Specialist:

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Comments:

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MENTAL HEALTH AND BEHAVIOURAL DISTURBANCE

Does patient have a diagnosed mental illness? Yes No

Diagnosis type

Is patient being medicated to treat a mental illness? Yes No

Is patient under the care of a mental health professional(s) Yes No

Is patient being medicated in order to control his/her behaviour when he / she does not have a mental illness? Yes No

Is a Behaviour Support Specialist Worker involved with your patient? Yes No

Is a referral for Specialist Behaviour Support indicated? Yes No

Is a referral to Mental Health Services indicated? Yes No

Comments:

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OTHER INVESTIGATIONS

Are any further investigations necessary, if so what investigation?

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SYNDROME SPECIFIC CHECKS

If patient has a known syndrome causing intellectual disability, have the health co-morbidities been assessed (Refer Syndrome Specific Checklist) Yes No

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For example, If Patient has Down Syndrome:

Has thyroid dysfunction been excluded Yes No (this should be annual)

Has Coeliac Disease been excluded Yes No

Is dementia suspected Yes No

Date:

Signed by GP:

Thank you.