Health Care Oversight

State of Tennessee

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Providing for Another Persons Health

Maintaining someone's health and well being should be viewed as a support necessary for successful living in the community. This support needs to mirror (albeit formally) what anyone would do for themselves to support their own health and well being. This would include considering health in everyday life (e.g. exercise, sleep, avoidance of toxic materials, etc.), maintaining a relationship with the health care system (i.e. personal physician, specialty clinics), partnering with the health care system (providing necessary information for treatment, asking questions, following through with recommendations) and maintaining appropriate documentation. The primary responsibility for health care maintenance lies with the person or agency supporting someone with mental retardation with the help of DMRS in the areas of technical assistance and monitoring, education and consultation.

Health Care is a PARTNERSHIP between the individual (or the individual's support system) and involved clinicians. This partnership requires the organization of information, preparation for appointments; follow through with recommendations and joint participatory communication. When supporting health care for another person, particularly someone who cannot verbally communicate in an easily understandable way, carefully kept medical records frequently take on expanded importance. Past medical history, specialty visits, hospital, emergency room and psychiatric visits are important in understanding the context and severity of presenting problems. Well-kept records avoid unnecessary intrusion or trauma and help avoid the cost of repeating treatment that has already been found to be ineffective or resulted in unwanted side effects.

Taking responsibility for another person's medical care requires:

- an understanding of the multi-faceted medical process
- understanding complex issues of health care
- the ability to accurately outline symptoms and problems
- knowledge of the person's medical history
- ability to ask questions
- ability to pass clear and complete information on to others

Good health care is necessary to assure maximum independence and function. Accepting this responsibility includes support or making provision for any health issues that someone would do for themselves if they are unable to do so due to cognitive deficits, communication problems or inability to understand medical issues. As far as possible, individuals should be encouraged to have input in their own health decisions. Family and legal

representatives must be kept informed of health issues and included in important decisions. They are the only ones who can make legal health decisions (e.g. sign for surgery, etc.) Issues of guardianship or conservatorship should be discussed at the yearly ISP.

Following are categories of health care areas which are done by persons in supporting their own health care that may need to be taken over by someone else depending on the ability of the person to do these tasks himself:

1. Understanding health care issues, to include acute and chronic illness, preventive care, behavioral issues and disability or diagnosis specific care to include ALL diagnoses. This includes addressing wellness issues such as weight control, exercise, smoking, etc. As these issues affect daily life they need to be interpreted in the light of the overall ISP and applied to issues of daily living. Persons health issues should not be the main focus of their lives but in order to live a full life, they need to be integrated into all parts of their life.
2. Maintenance of information about past medical history upon which all current care may depend. This saves persons from repeating expensive and perhaps uncomfortable tests and procedures and protects them from exposure to past treatment failures or medication side effects. Basic medical information for emergency care should be available at all times and more extensive accurate information needs to be readily and concisely available for routine and specialty care. As most people plan for scheduled care, this component should also be considered. A health passport should be available for emergency use and concise, organized records of both past and current medical care be available for current care.
3. Maintaining a relationship with health care providers which includes accessing care, going to appointments, partnering with clinicians (e.g. asking questions, understanding treatment, etc.) providing accurate health care information, following through on recommendations and reporting problems (e.g. treatment not working, medication side effects).
4. Supporting health care treatment recommendations (either independently or with another clinician such as a nurse or therapist) including symptom recognition, medication administration, treatment regimens, nutrition issues, bowel and bladder care, device maintenance and appropriate scheduling.
5. Understanding parameters of symptoms and changes in health including recognizing acute illnesses, change in chronic illness presentation and recognition of emergency needs. This would include plans to address these issues.
6. Accurate, timely and appropriate administration of medications as prescribed as well as understanding of purpose, outcome or possible side effects and when to ask questions or notify prescriber.
7. Understanding and cooperation with therapy recommendations.
8. Understanding of and participation in basic activities supporting basic wellness such as weight control, exercise, stress reduction, etc. as recommended for all citizens.

9. Monitoring and awareness of basic bodily functions (bowel and bladder, sleep) that may contribute to health or be signs of health problems.
10. Planning for care of serious illness, and, where appropriate considering end of life care.
11. Understanding importance of dental care in health maintenance as well as comfort and following recommendations for dental care that is routine, preventive and treatment oriented.
12. Understanding how health care issues may affect emotional well-being and personal behavior.
13. Understanding allergies and symptoms and have a plan of action for life-threatening allergies.
14. Supporting periodic health evaluations as well as regularly scheduled specialty follow up visits. Maximizing all doctor visits through careful planning.
15. Have clear understanding of all medication, treatment or referral recommendations made by treating clinicians.
16. Inquire about risks of treatment, prognosis of health problems and understand course of treatment for acute and chronic problems.
17. Make health care wishes clear including wishes if incapacitated and designate someone for making these decisions.

Health Care Oversight Form

Why must this form be completed?

The health care oversight form is an assessment which must be completed prior to the annual planning meeting for the Individual Support Plan (ISP). This form addresses all medical encounters of the prior year. Information comes entirely from medical records that the agency has been maintaining over the course of the prior year. This information provides a basis for discussion about health issues for incorporation into the rest of the person's life.

How do I complete the Health Care Oversight form?

The form is to be completed by the assigned agency provider. It should be legible and preferably done in black ink.

Name: Use the name of the individual, and do not use nicknames.

DOB: Use the date of birth of the person.

Age: Refers to the age of the person.

Date: Use the date the form was completed. (00-00-0000)

All medical care begins with diagnoses and understanding medications. The first part of the form relates to diagnoses and current medications. This relation will help with understanding treatment modalities (forms of treatment) and the possibility of medication side effects as well as the effectiveness of treatment. If diagnoses are unclear, this should be discussed with the PCP.

A simple way to begin is to list diagnoses in one column and the corresponding medication in another column. List the diagnosis and then the medication being used directly opposite. More than one medication may be prescribed to treat a single diagnosis. Some diagnoses do not require treatment with a medication. (E.g. Mental Retardation, Cerebral Palsy) When there is no treatment using medication, leave the area for medication "blank".

There may be some diagnoses that should be treated with medication, yet are not being treated with a medication. This raises issues for discussion. Having no medication treatment could either mean that this is a resolved diagnosis, that the medication was inadvertently dropped, or that the person needs to revisit the need for medication. The most common gaps are found on the medication list where a person is receiving a medication, but has no corresponding diagnosis. In this case it should be discussed whether or not the person needs continued treatment, needs an evaluation to establish diagnosis, or if the medication is inappropriate.

What is a Diagnosis?

The medical diagnosis is determined by the physician. A diagnosis is the identifying of an illness or disorder in a patient through an interview, physical examination and medical testing and other procedures. It generates a diagnosis based on the patient's symptoms, and other findings and it provides treatment options.

Diagnoses may be medical or psychiatric. Some may include abbreviations or other codes with numbers and letters. Copy the diagnoses as listed by the physician. List only one diagnosis per line. If there is not enough room, finish information on back of the form. Please indicate if there are additional diagnoses listed on the back of the form.

What medications are to be listed?

List the medications as they appear on the current MAR (medication administration record) for the individual. It is not necessary to indicate the dosage or the frequency of the medication. List the medication used exactly opposite the corresponding diagnosis. Include regularly used OTC (over the counter) medications.

List the medication that is used for each medical or psychiatric diagnosis. A single diagnosis may have several medications indicated for treatment. More than one medication can be listed per line. Also, list medications given on a regular basis when they are only given in a doctor's office. (E.g. allergy shots, depo provera, etc.)

Some diagnoses may not require a medication, such as mental retardation, in which case the line for the "medication" just opposite the diagnosis will remain "blank", or a single straight line may be drawn in the space.

PRN medications may be listed or can be addressed on the back of the form. PRN medication used on a regular basis should be reviewed. Note if used more than once a month or are used recurrently. Indicate if additional medications or PRNs are listed on the back of the form.

In general, most diagnoses are active but some prior diagnoses, although resolved may be important to list as they may indicate current risk. These diagnoses are generally identified as S/P (status post). Examples might be S/P mastectomy, S/P hydrocephalus with inactive shunt, S/P GI surgery, etc.

Types of Care

Acute care—illness, accidents, etc. are fairly well understood by most people and may require an ER visit. If this occurs frequently, (e.g. pneumonia, injury from falls or SIB, recurrent impaction) it may be indicative of some underlying chronic medical issue.

Chronic care --- Includes such diagnoses as diabetes, seizures, schizophrenia, and osteoporosis which require consistent care over time and usually do not resolve. Many chronic diseases have complications over time and this must be considered and planned for. (E.g. diabetes) Many chronic diseases (E.g. epilepsy) are improved by newly discovered treatments (E.g. VNS) and medications (E.g. Keppra) and should be reviewed periodically. Many acute events, such as stroke, become chronic diseases.

Preventive care --- Persons with MR have, in the past, sometimes not received routine screenings because it has either been thought not important (they wouldn't live very long) or it would be too uncomfortable for them. All individuals should receive appropriate screenings as recommended by national health organizations. (Available on the internet) Some preventive procedures can be a bit uncomfortable but there are many interventions (adaptation of tests, sedation, etc.) that can be used to help make things go more smoothly.

Diagnosis specific care --- Many diagnoses in people with MR have associated predictive value. This can be helpful in anticipating medical problems. For example, we know that people who are non-ambulatory and are non-self feeders are at high risk for dysphagia and GERD. Persons who have received long term treatment with Dilantin & Phenobarbital are predisposed to osteoporosis. Diagnosis of a genetic syndrome often provides a "road map" for medical care. This is the place to address if any activity has occurred relating to these issues. Specific tests, follow-up appointments or screenings related to clinically diagnosed syndrome and the underlying medical conditions are placed in this category. These areas should be reviewed either with a clinician or in some cases, with written information and the risk of these problems for the person with this diagnosis. For example, a diagnosis of Down Syndrome carries a risk of hearing loss, vision disorders, thyroid dysfunction, constipation and Alzheimer's disease, just to name a few. Another example is Prader-Willi Syndrome. This individual may have problems related to obesity, which may include high blood pressure, diabetes and respiratory difficulties. Consistent behaviors have also been identified. Ideally, this should be discussed with the PCP who should review and discuss the risk for these problems for the person with this diagnosis.

All interactions with clinicians addressing these problems during the last twelve months are problems to be addressed in these areas.

Dental Issues

Good oral hygiene and healthy teeth contribute not only to dental health but overall general medical health. (Poor oral hygiene is linked with heart attacks.) In addition, poor dentition or discomfort may contribute to nutritional or behavioral problems.

People with MR have the same range of difficulty with dental care as experienced by most of us. These issues can often be avoided by good oral hygiene or adaptations relating to dental visits such as desensitization, careful planning, sedation and, in a minority of cases, anesthesia.

Oral examinations and cleanings are important to overall health. Dental issues will be addressed in this area. Include areas of need for such issues as cavities, gum disease, denture repair or replacement, etc.

Include dental appliances, dentures or braces in this section.

It is also important to include any modifications the individual may require such as sedation, pain relief, and treatment (pre or post) with antibiotics related to dental care.

PSR Score and Date

Indicate the score from the Physical Status Review (PSR) and the date the PSR was completed.

Consent Status

In many cases, people with MR can give their own consent or may have limited consent. (Can choose where they live but not sign for surgery.) Consideration here should relate to the ability to consent as it relates to medical issues including testing, surgery, DNR, etc. In general, people below age 18 have decisions made by their parents. Adults who are deemed incompetent to make decisions need to have a legally appointed conservator and this should be decided in the county in which they reside. In many cases, adults without legally appointed conservators will have decisions for care made by family which will be accepted but this is not always the case. Consent issues for people with aging parents may also pose problems. Various possible scenarios can be considered before a crisis situation arises. If a person has been adjudicated as incompetent and assigned a legal representative, the agency must maintain a copy of this form in the records. Health care decisions must adhere to the Tennessee Health Core Decisions Act TCA 68:11 Section 68 – 11 -1701, amended June 2004.

DNRs (do not resuscitate) require careful consideration and should only be in place for a known reason (terminal illness, futility of treatment, etc.) The decision is between the patient or legal designee and the patient's doctor. However, those supporting a person should be involved in discussion where appropriate. In addition, regulations recently enacted by TNDOH must be followed. (This mainly refers to proper forms and consent laws.) Resuscitation can also be designated to be partial – e.g. oxygen used but no cardiac meds.

DNR comfort care must be carefully discussed. Indiscriminate use of medications (e.g. morphine) should be avoided. Comfort care should be carefully outlined so as to support someone but not hasten death.

Health Care Proxy

A health care proxy is when a person designates someone else to make decisions for them.
Only persons who are deemed competent (or who are not deemed incompetent) can execute a health care proxy.

Resuscitation Status

The agency providing services must report to the DMRS Regional Office when a Do Not Resuscitate (DNR) is obtained for an individual. (This is usually reported via the crisis pager.)

DNR_____	Person has a valid "Do Not Resuscitate" order in place from a clinician.
Full Resuscitation _____	Person will receive all medically necessary efforts to restore life.
If DNR, is comfort care addressed _____	If "unknown" is chosen, the agency must address the issue with the clinician placing the DNR status.

DNR orders and appropriate forms must be in accordance with Tennessee state law.

Communication

Able to communicate _____	Person is able to effectively communicate needs and wants in a manner that is understandable to staff. Communication devices (word boards, electronic equipment, etc.) are to be considered when evaluating the ability of a person to communicate, and should be noted.
Communication difficulties/uses verbalizations _____	Person uses sounds, grunts, crying or a few words. Person may be able to effectively communicate needs & wants to others using these verbalizations.
Communication difficulties/uses gestures _____	Person uses gestures (pointing, nodding, eye contact, hands on directing) to communicate needs and wants to others.
Not able to communicate needs _____	Person has no means to communicate to others their needs and wants. For example, a person with a tracheal tube who makes no audible sounds, and who is also unable to move their hands or arms to express needs.

Vision

Normal _____	Person has “normal” vision. Sometimes referred to as “20/20” vision. The person does not require glasses or contacts.
Low vision _____	Person has been told by their eye care professional that their vision cannot be fully corrected by ordinary prescription lenses, medical treatment, or surgery, and that they still have some usable vision. Low vision can result from specific eye conditions, such as cataracts, macular degeneration, glaucoma, and diabetic retinopathy, or from a stroke.

Vision (Cont'd.)

Blind _____ A person is considered LEGALLY blind when the best corrected visual acuity is 20/200, or the person's visual field is 20 degrees or less. It is not true that all blind persons have absolutely no sight; in fact, most blind persons have some remaining vision.

Wears glasses _____ A person wears or uses glasses or contacts for the purposes of correcting a vision problem or improving vision. Correction of such problems as nearsightedness (myopia), farsightedness (presbyopia), and astigmatism are common. Corrective lenses may allow for a person to experience "20/20" vision.

These categories should be substantiated by examination by an eye care specialist although with some people who cannot cooperate with testing, careful observations may be used as an estimate.

Hearing

Normal _____ Person has hearing ability that falls within a specified range of normal capacity.

Hard of Hearing _____ Person has loss of hearing sensitivity.

Deaf _____ Person has no or very limited functional hearing.

Hearing Aid _____ Any device designed to amplify and deliver sound to the ear, consisting of a microphone, amplifier, and receiver.

These categories should be substantiated by examination by an audiologist although with some people who cannot cooperate with testing, careful observations may be used as an estimate.

Supportive Devices

Padded side rails _____	Side rails of the bed are padded to provide added protection and safety for the person.
Splints _____	A device worn on the body to protect a broken bone or injury or sometimes for specific positioning.
Braces _____	A device worn on the body to provide protection, treatment to prevent progression and to maintain appearance of the body part. Do not include dental braces in this section.
Helmet _____	Provides protection to the head. Include helmets worn by individuals with seizures as well as for those who ride bicycles. Specify if for medical or behavioral reasons or safety.
Other _____	List other supportive devices used. This would include other adaptive equipment such as shower chairs, portable toilets, etc.

Toileting

Continent _____	Person has control over bodily discharges and personal hygiene needs.
Needs assistance _____	Person requires assistance to toilet and meet hygiene needs.
Incontinent _____	Person is incapable of controlling excretory functions. Includes persons who routinely wear adult briefs. Note if only used in special circumstances (e.g. overnight, extended activities, etc.)
Catheterized _____	Person has a catheter in place for urinary incontinence.
Other _____	List other issues with toileting.

Personal Hygiene

Independent _____ Person can complete all personal hygiene needs (bathing, toileting, etc.) Some people may only require prompts, reminders or supervision.

Special needs _____ Person requires physical assistance with personal hygiene needs.

Oral Hygiene

Independent _____ Person can complete oral hygiene (brush, floss, use of mouthwash).

Special needs _____ Person requires assistance to complete oral hygiene. List the special assistance required, such as flossing, special toothbrush, special oral products.

Elevation of Head of Bed

Yes _____ Head of bed is raised. Bed frame may be elevated on blocks, mattress may be elevated, or hospital type bed may be elevated at the head area. Use of a pillow (to elevate the person's head) does not involve elevation of the head of the bed.

No _____ Head of bed is not elevated.

Medication Administration

Independent/self medicates _____ Person uses prescription medication in a manner directed by the prescribing practitioner without assistance or direction by program or facility staff, in accordance with DMRS standards.

Medication administered by staff ____ Certified staff administer medication to person.

Dining & Eating

Independent _____	Person may require simple adaptive equipment (hand splints, special utensil). Able to eat without assistance. Exception: meal preparation (cutting meat).
Needs assistance _____	Person has difficulty attending to task and/or needs direct physical help due to motor limitation. With assistance, is able to safely complete meal.
Totally dependent _____	Person is unable to obtain adequate calories and fluids without assistance. May have difficulty breathing/swallowing while eating or condition that impairs ability to eat safely. Interventions are required (specific positioning support, eating devices, presentation techniques, modifications in food/fluid consistency). May have enteral (feeding) tube, but maintains some level of oral eating.
Fed through a tube _____	Person receives all or some nutrition or fluids through an enteral tube (gastrostomy, jejunostomy, etc.)
Other _____	List other means of nutritional support. TPN (Total Parenteral Nutrition) would be listed here.

Diet Texture

Regular _____	There are no dietary restrictions in place.
Chopped _____	Food is required to be cut into designated size pieces according to dining plan restrictions.
Ground _____	Food is required to be ground according to dining plan restrictions.
Puree _____	Food is required to be of a puree consistency according to dining plan restrictions.
Thickened liquid _____	Liquids are required to be thickened to a consistency according to dining plan restrictions.

Diet Type

List the diet as prescribed by the person's primary care provider. This would include restrictions such as 1800 calorie diet, low sodium diet, renal diet, low cholesterol diet, low fat diet, etc. Use of dietary supplements on a regular or intermittent basis should also be included.

Ambulation

Independent ambulation: Person is capable of walking, not bedridden. May use walker or other means of support without problems of safety.

Steady: Person is stable in continuous movement.

Unsteady: Person is unpredictable in continuous movement.

Needs Assistance: Requires some type of support (walker) with support of another (person) in close proximity. The primary issue is safety during ambulation. Also choose this option for a person who requires assistance to propel a wheelchair.

One person: Needs someone to supervise for safety.
Two people: Person needs assistance of two persons for safety.

Ambulation aids: Any assistive device used by the person for ambulation purposes.

Walker: A frame device used for support during ambulation.

Cane: A device used as an aid in walking. Usually a slender, stick-like device designed to be held by only one hand.

Crutches: Support used as an aid in walking, usually designed to fit under the armpit or forearms and often used in pairs.

Wheelchair: May be manually or electrically powered.

Non-ambulatory: Person is unable to walk about. Also choose this option for a person who is able to "scoot" or "crawl" about, or requires a wheelchair to move about, but is not able to stand to walk.

Equipment Used

Cleaning Schedule: Indicate the directions and the responsible shift assigned to clean the equipment.

Repair/replacement schedule: Indicate the date the equipment was sent for repair or indicate the date the equipment should be considered for replacement.

Immunizations

The Primary Care Provider (PCP) makes recommendations for immunizations based on health status of an individual as well as national standards.

Some immunizations require a series of injections, while others are a single injection that may be repeated on a yearly basis. For each selection, there is a space for the date of the last immunization.

Unknown: There is no date showing the immunization has been completed, yet the individual or family may indicate the person has had the required immunization. The agency must address the reason for this lack of date.

Allergic: There is evidence of an allergic reaction to the immunization and the PCP has addressed the issue. It may be recommended that the individual not receive the immunization.

Never: It is reported that the individual has never received any immunizations. There are no restrictions or reported allergy. There is no history of immunizations. The agency must address the reason for the lack of immunizations.

Tuberculosis Skin Test (PPD)

Check with the PCP or the local Health Department to determine the need for a tuberculin skin test. The CDC (Centers for Disease Control and Prevention) have established guidelines and recommendations for TB testing.

The tuberculin skin test can show if the person has ever been "infected" by tuberculosis (TB) germs. There are several kinds of tuberculin skin tests. The most reliable test called the Mantoux PPD. Persons who have had a TB immunization (BCG) will test positive and may need an x-ray if testing is warranted.
If the skin test reaction is negative, a person will only need to take the PPD skin test again if he/she is exposed to

someone with active TB, has symptoms of TB, or if it is a requirement for school or work.

If the skin test reaction is positive, future reactions tend to remain positive. Therefore, a person should not take the skin test again but should save the record of this skin test. It may be needed by a doctor, school or an employer in the future. The PCP may elect to do a chest x-ray in lieu of PPD in this case.
If a person with proof of positive skin test reaction is required to have TB testing for school or work, he/she should not have a skin test but should follow the requirements of the school or agency.

List any treatment received for a "positive" result.

Indicate date of last PPD.

Special Needs

This section may be useful for planning medical encounters.

Response to medical exams

Compare to average person. A more complete explanation can be filled out on the back of the sheet.

Sedation

Note medications that have been both effective & ineffective. Give medication and dose of most effective, if used.

Positioning

Note physical limitations for examinations and procedures. Describe adaptations.

Extra staffing

Outline personal supports needed.

Appointments

Note preferences and problems.

Communication

Note if needs communications device.

Pain Response

Describe if unusual.

Primary Care Provider (PCP) and Specialists

Indicate the complete name, address and the phone number of the primary care provider (PCP). Include all if changed during the year. If new PCP, add date of first visit and check to see if records were transferred.

Indicate the complete name, area of specialty, address and the phone number of any clinician that the individual has seen during the last twelve months. If not enough space, include additional clinicians and information on the back of the sheet.

Examples of specialists may include, but are not limited to: Gastroenterology, Internal Medicine, Podiatry, Obstetrics and Gynecology, Neurology, Dermatology, Oncology, Psychiatry and Orthopedics.

Medical History

Include in this section for medical history a brief summary of the dates, and reason for the visits to the PCP and specialists during the last twelve months. Include the date and any recommendations from the last annual physical examination. This section is also the place to identify all emergency room visits and hospitalizations, minor illnesses (colds, rashes, etc.), accidents or falls.

Behavior Supports & Strategies

Include in this section a brief summary of behavioral supports or strategies used. This will assist others in keeping the individual safe. Include in this section any methods used when the person displays self-injurious behavior. Specific plans for clinical issues (e.g. dental care, blood drawing, etc.) should be included here.

Tardive Dyskinesias (TD) Screening

Tardive dyskinesias (TDs) are involuntary movements of the tongue, lips, face, trunk, and extremities that occur in patients treated with certain long-term psychotropics and a few other medications such as Reglan.

By using a standardized rating method such as the Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System: Condensed User Scale (DISCUS), clinicians conduct a surveillance of TD. Screening may be performed by a doctor (psychiatrist), nurse or other health care professional. Assessments are completed on an ongoing basis. List the date, score, and recommendations from the screening.

Tobacco or Alcohol Use

Tobacco Use: Please indicate if the person smokes or uses smokeless products. Also include the amount used per day. If person does not use tobacco products, simply answer as "No".

Alcohol Use: Please specify alcohol consumption and indicate amount per day. If person does not use alcohol, simply answer as "No."

Seizures

For a person with a diagnosis of seizures, indicate the overall number of seizures observed and recorded during the last twelve months. If significant, can state "see attached" and attach cumulative seizure form.

For a person with a diagnosis of "seizures by history", and there has been no seizure activity during the last twelve months, indicate with the following: "seizures by history, no seizure activity noted during last twelve months". If possible, give date of last seizure for review.

For an individual without a seizure diagnosis, use "NA" or "not applicable".

Laboratory testing is completed according to the clinician's orders.

The results may or may not be available to the agency provider.

When these results are available, list any abnormal values that have been addressed by the clinician. Often the clinician may simply request a repeat of a test or choose not to treat an abnormal value.

Include abnormal date and value, and the resolved date and value (when available) during the last twelve months.

Investigation in this section would include any testing that has been completed related to the persons' health during the last twelve months. Include such things as MRI, CT or bone scans, investigational medication, etc.

List the name of the test/drug and the date completed.

Internal Devices

Pacemaker: Individual has a pacemaker implanted.

Vagal nerve stimulator: Individual has a vagal nerve stimulator (VNS) implanted.

Other: List the device. Include such things as joint replacements, any pins, rods, plates, Baclofen pumps, Port-A-Cath, etc.

Other Data

Not every person will require all of the following be addressed. For those individuals who do not require a response, simply write "NA" or "not applicable" in the space provided. If data is being kept and not used, consider why and if it needs to be continued. Much of this data is very valuable but not presented to people (e.g. PCP) who might find it helpful. Note if data sheets are available and why they are kept. Sometimes data sheets are helpful in monitoring symptoms and treatment.

Behavior: List behavior concerns.

Elimination: List problems with elimination (constipation, diarrhea, urinary infections, urinary incontinence, etc.)

I & O/ Food intake: List concerns with intake and output (I & O) of food and fluids.

Menses/ breast exams: List irregularities of the menstrual cycle and/or breast exams.

Sleep: Indicate problems with disruptive sleep patterns.

Weight: Address unplanned weight gain or loss. An assessment of monthly weight values will help with determining the significance of the gain or loss.

Quarterly psychiatric reviews: List concerns presented during the quarterly psychiatric review.

Other: Write the name of the concern for the person under the "type" column and then address any concerns. There is an additional line for the listing of any other concerns. Such things as Blood Pressure (BP), blood sugar levels (blood glucose), etc. If data is consistently good or if not being used for a specific issue, discussion should address why it is being kept and if it is necessary to continue.

Have medication side effects been reviewed? Indicate by using "yes" that a complete review of the

medication side effects has occurred. List the name of any medication that seems to be causing the person problems and the date this was addressed with the clinician. For those individuals who do not take medications, simply write “NA” or “not applicable” in the space provided. Medication side effect information is often overwhelming, especially when someone is on many medications. Resources such as pharmacy, the internet, PCP, etc. may be utilized.

Are there any sexuality issues to be addressed? This would include such issues as masturbation, sexual activity, and possible risk of abuse.

Use the questions section to ask questions that need to be raised during the annual ISP. These concerns will be based on the review of the completed health oversight assessment. This might also generate a list of questions to be presented to the PCP or other clinician.