HEALTH CARE OVERSIGHT

NAME_____**DOB**_____**AGE**_____**Date**_____

Understanding Medical Issues for Persons with Mental Retardation

All medical care rests on diagnoses. To understand medical problems, a simple way is to list diagnoses in one column and medications in another. List the medication used for treatment directly opposite the diagnosis. If there is no diagnosis matching the medication, the question arises if the diagnosis is not listed or if further investigation is warranted. If a diagnosis has no associated medication then it may be a developmental diagnosis not needing medication (e.g. mental retardation, visual handicap, contracture, scoliosis), may no longer be a valid diagnosis (i.e. problem is resolved) or treatment may need to be reassessed.

Diagnosis	**Medication**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical care for person's with developmental disabilities and mental retardation fall into four categories: acute, chronic, preventive and diagnosis specific.

List issues and events since last ISP which refer to clinical issues in the following categories:

PREVENTIVE	**ACUTE**
CHRONIC	**DIAGNOSIS SPECIFIC ISSUES**

Dental Issues:_____

_____

PSR score_____ Date_____

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NAME_____**DATE**_____

Consent Status: ⎕ Can give own consent. ⎕ **Unable to give own consent and no legal representative.**
⎕ Consent from legal representative
Name_____
Tel. #_____

Resuscitation Status: ⎕ DNR If DNR, is comfort care addressed? ⎕ Yes ⎕ No
⎕ Full Resuscitation ⎕ Unknown

Health Care Proxy ⎕ No ⎕ Yes Name_____Tel. #_____

Communication
⎕ Able to communicate
⎕ Communication difficulties/ uses Verbalizations
⎕ Communication difficulties/ uses Gestures
⎕ Not able to communicate needs

Vision:
⎕ Normal
⎕ Low Vision
⎕ Blind
⎕ Wears Glasses

Hearing:
⎕ Normal
⎕ Hard of Hearing
⎕ Deaf
⎕ Hearing Aid

Supportive Devices:
⎕ Padded Side Rails
⎕ Splints
⎕ Braces
⎕ Helmet
⎕ Other_____

Toileting Ability:
⎕ Continent
⎕ Needs Assistance
⎕ Incontinent
⎕ Catheterized
⎕ Other_____

Personal Hygiene:
⎕ Independent
⎕ Special Needs
_____

Oral Hygiene:
⎕ Independent
⎕ Special Needs
_____

Head of Bed Elevated:
⎕ Yes ⎕ No

Medication Administration
⎕ Independent/ Self Medicates
⎕ Medication administered by staff

Dining / Eating:
⎕ Independent
⎕ Needs Assistance
⎕ Totally Dependent
⎕ Fed through a Tube
⎕ Other_____

Diet Texture:
⎕ Regular
⎕ Chopped
⎕ Ground
⎕ Puree
⎕ Thicken Liquid

Diet Type: _____
_____

Ambulation:
⎕ Independent ⎕ Steady ⎕ Unsteady
⎕ Needs Assistance
⎕ 1 person ⎕ 2 people
⎕ Ambulation Aids
⎕ Walker ⎕ Cane ⎕ Crutches
⎕ Wheelchair
⎕ Non-Ambulatory

Any Equipment Used:

Cleaning Schedule:_____

Repair/Replacement Schedule:_____

IMMUNIZATIONS:

Date of last TETANUS_____	⎕ Unknown	⎕ Allergic	⎕ Never
Date of last FLU SHOT_____	⎕ Unknown	⎕ Allergic	⎕ Never
Date of last PNEUMOVAX_____	⎕ Unknown	⎕ Allergic	⎕ Never
Date of HEPATITIS B VACCINE			
Primary series (3 shots)_____	⎕ Unknown	⎕ Allergic	⎕ Never
Booster_____	⎕ Unknown		⎕ Never
Date of MEASLES/MUMPS/RUBELLA_____	⎕ Unknown	⎕ Allergic	⎕ Never

List any other vaccinations and date (e.g., Lyme, Hepatitis A, Varicella, etc.)_____
_____

TUBERCULOSIS SKIN TEST (PPD):
Have you ever had a positive skin test for tuberculosis? ⎕ Yes ⎕ No ⎕ Unsure
If yes, was any treatment given? ⎕ No ⎕ Yes (describe)_____
Date of last PPD_____

SPECIAL NEEDS: Usual response to medical exams ⎕ Cooperates ⎕ Partial Cooperation ⎕ Resistant ⎕ Fearful
⎕ Sedation for clinical visits (explain)_____
⎕ Special positioning required for examination (explain)_____
⎕ Extra staffing required for examination (explain)_____
⎕ Prefers early day appointments ⎕ Prefers end of day appointments ⎕ Limited waiting periods for exams
⎕ Special communication device/method (explain)_____
Pain Response: ⎕ Normal ⎕ Unique (explain)_____
Nursing Supports Available: ⎕ No ⎕ In home ⎕ In home 24 hours ⎕ Nursing Coordination ⎕ Access to _____
_____

HEALTH CARE OVERSIGHT

(Should be filled out by agent or agency supporting medical care and should be based on medical encounters of the past year. Should be discussed in preparation by agency, caregivers and Circles of Support)

Name_____**Date**_____**DOB**_____**AGE**_____**M**__**F**__

PCP_____
ADDRESS_____
_____PHONE_____

SPECIALISTS - NAME:_____ AREA OF SPECIALTY:_____
ADDRESS_____
_____PHONE_____

SPECIALISTS_____
ADDRESS_____
_____PHONE_____

MEDICAL HISTORY (Past year—ER, hospitalizations, illnesses, etc.):

_____

_____

_____

_____

BEHAVIOR SUPPORTS/STRATEGIES_____
_____

TD SCREENING _____

TOBACCO USE_____ALCOHOL USE_____

SEIZURES (Last year): _____

PERNINENT LABORATORY /INVESTIGATIONS (Last year): _____
_____
_____

INTERNAL DEVICES: Pacemaker_____ Vagal Nerve Stimulator_____ Other_____

OTHER DATA AVAILABLE:

TYPE	**ISSUES**
Behavior	
Elimination	
I&O/ Food Intake	
Menses/Breast Exam	
Sleep	
Weight	
Quarterly Psychiatric Reviews	
Other (BP, Glucose, H&H, etc.)	

Have medication side effects been reviewed? _____

Are there any sexuality issues to be addressed?_____

QUESTIONS:_____

_____

_____