

Skin:..... Feet:..... Women's Health Review Pap smear:..... Breast check: Mammogram: Menstruation Problems?	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Men's Health Review Testes: Prostate: (Age 60+)	Yes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
Dental	Decay? <input type="checkbox"/> Regular dentist?..... <input type="checkbox"/> Last dental visit =	? Dental referral Y/N
Hearing	Ear canals clear... <input type="checkbox"/> Whispered words at 3 m <input type="checkbox"/>	?Audiometry referral Y/N
Vision	Normal <input type="checkbox"/>	? Ophthalmology/ Optometry referral Y/N
Medication	Yes <input type="checkbox"/> No <input type="checkbox"/> No. of medications = Indications? Adverse effects?	? Need for Home Medicine Review (Item 900)

Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/> Type: Generalized <input type="checkbox"/> Partial <input type="checkbox"/> Well controlled? Date of last seizure = Pseudoseizures? (Behavioural) <input type="checkbox"/>	
Diet	Normal <input type="checkbox"/> <input type="checkbox"/> ? Referral to dietitian Abnormal <input type="checkbox"/> Nutrition and Swallowing risk assessment <input type="checkbox"/> Difficulties swallowing <input type="checkbox"/>	
Bowel Review	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Recent changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Incontinence <input type="checkbox"/>	
Gastro-Oesophageal Reflux	Recurrent vomiting / aspiration <input type="checkbox"/> Dental erosions <input type="checkbox"/> Poor growth/nutrition? <input type="checkbox"/> Gastroscopy / Ba.meal <input type="checkbox"/>	
Sleep Pattern	Normal <input type="checkbox"/> Frequent waking <input type="checkbox"/> Apnoeic episodes <input type="checkbox"/> Loud snoring <input type="checkbox"/>	
Behavioural	Normal <input type="checkbox"/> Aggression <input type="checkbox"/> Self injury <input type="checkbox"/> Injures others <input type="checkbox"/>	
Mental Health	Normal <input type="checkbox"/> Anxiety <input type="checkbox"/>	

	Depression <input type="checkbox"/> Psychosis <input type="checkbox"/>	
Exercise	Yes <input type="checkbox"/> No <input type="checkbox"/> Times per week = Minutes per session =	
Mobility	Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Stick <input type="checkbox"/> Wheelchair <input type="checkbox"/> Frame <input type="checkbox"/>	
Bladder	Normal <input type="checkbox"/> Incontinence <input type="checkbox"/>	
Osteoporosis Review	Not applicable <input type="checkbox"/> Risk factors present <input type="checkbox"/> DEXA Scan <input type="checkbox"/> Year:	
Immunisation		
Hepatitis A:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hepatitis B:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Influenza:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Pneumovax:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
ADT:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Lipids/Diabetes	Date: _____	
Cholesterol:	= _____ mmol/L	
Fasting BSL:	= _____ mmol/L	
Thyroid Function (Downs Syndrome)	Date: _____ TSH = _____	
Atlanto-axial Instability (Downs Syndrome)	Cervical spine Xray Date: _____ Instability: Yes <input type="checkbox"/> No <input type="checkbox"/>	

Recommendations for Care Plan: (copy of plan to go to each care provider)

Care Provider:	Service Provided:	Time frame for Referral:
	Mental Health / Psychologist	
	Psychiatrist	
	Social Worker	
	Home Medicine review	
	Optometrist / Ophthalmologist	
	Audiologist	
	Speech Therapist	
	Dentist	
	Physiotherapist	
	Occupational therapist	

	Podiatrist / Foot care RN	
	Dietitian	
	Educator	
	DADHC community support team	

Full health summary may be added from Medical Director

Past History:

Family History:

Social History:

Medication list:

Immunisations:

PAP smears: