

New England Intellectual and/or Developmental Disability Checklist.

Providing the best care for those people with an Intellectual and/or Developmental disability

The aim of the health assessment is to provide a structured clinical framework for GPs to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventative health care required. If an assessment identifies that a patient has a chronic medical condition and complex care needs, it may be appropriate to involve other health professionals in the patient's care using the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items for GP Management Plans and Team Care Arrangements (see items 721-731).



New England Division of General Practice (NEDGP) is working towards

- Maintaining and improving standards of General Practice
- Bringing General Practitioners closer to the community
- Identifying the health care needs of the community within its boundaries and facilitating programs and services to meet those needs
- Providing educational and practical support for the optimal delivery of primary health care in the Division area
- Facilitating links between General Practitioners and other health care professionals throughout the Division
- Promoting research programs which focus on issues relating to rural General Practice

213 Rusden St, Armidale, 2350 NSW
Send to : PO Box 1321, Armidale NSW
Contact : 02 6771 1146 Fax: 6771 1170
www.nedgp.org.au



New England Intellectual and/or Developmental Disability Checklist.

Providing the best care for those people with an intellectual and/or developmental disability

Patient Information





New England Intellectual and/or Developmental Disability Checklist.

Cognitive and communication difficulties can make it difficult for people with intellectual disability to recognise and communicate pain, discomfort or other symptoms of ill health.

As a result, reliance is often placed on family members or support workers to bring health problems to the attention of the General Practitioner, and to provide a medical history. However, these support people may also be unaware of symptoms, and with a constant turnover in support staff, an accurate history may be difficult to obtain.

Physical examination may sometimes be difficult due to anxiety or behaviour difficulties in the person with intellectual disability.

“Diagnostic overshadowing” – this is a phenomenon where clinicians may ascribe physical or behavioural symptoms to the intellectual disability, and not look for associated physical or mental health disorders. The disability is often seen as the illness and other routine general health screening is not conducted. This can lead to some conditions being overlooked.

It is recommended that people with an intellectual/developmental disability be seen **ANNUALLY** by their family doctor (GP) for a comprehensive and structured health check. It is important to set aside adequate time to complete this process with **two 30-minute consultations, 3-4 weeks apart (Steps 2 and 3)**.

Step 1. Completion of the Health Questionnaire. This is best done by the principal carer (family member or key-worker). This questionnaire is then given to the GP at the beginning of the first consultation (Step 2), which is booked as a long consultation . The patient should bring ALL medication and a sample of urine.



Step 2. Long Consultation (Item 718) (minimum 30 mins) with GP to review the completed questionnaire and to begin the structured annual health check. The checklist helps identify chronic conditions which can be managed using a GP Management Plan (Item 721). A Home Medicines Review (HMR) referral should be considered at this first consultation.



Step 3. Second consultation (30mins): completion of the GP Management Plan (Item 721) and/or a Team Care Arrangement (Item 723) with referrals to specialists, other health professionals (5 EPC Medicare referrals annually) and other Divisional Programs where appropriate. Complete the HMR Management Plan if undertaken (Item 900).



Step 4 (Follow up): Review six monthly (30minutes, Item 725,727) to review outcome of referrals and the care plan. The checklist is done annually but the GP Management Plan is usually done every 2 years unless there is a health change.