

Preventative Health Practices

What is going on?
What can we do about it?

Cindy Chatzis, RPN
Healthcare Facilitator
Southern Network of Specialized Care

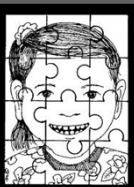
Overview

- Intellectual / Developmental Disabilities (I/DD) & Health Trends
- Barriers
- Overview of Specific Issues
- Prevention & Screening
- Evidence-Informed Resources in Aging, I/DD & Complex Behaviours
 - NTG guidelines & NTG-Early Detection Screen for Dementia (NTG-EDSD)
 - DD Primary Care Guidelines & Tools
 - Other Resources



What is Going On?

- Increasing life expectancy of people with I/DD
- Age-related diseases more prevalent
- Higher Co-morbidities
 - Seizures, CVD, dental, GERD, constipation, obesity, Mental Health issues
- More than 2x usual medical conditions
- Earlier onset of some conditions



Aging & DD Key Issues

- ◉ A number of factors contribute to the marginalization of seniors with developmental disabilities:
- ◉ Mainstream info on disease prevention may not be reaching individuals with DD
- ◉ Rarity of experts on aging with DD
- ◉ Difficulties of communication
- ◉ Preventable or undiagnosed conditions & lack of access to proper care or other services in the areas of physical or mental health
- ◉ Less or lack of social & financial supports



(Lunsky et al., 2013; NACA, 2004)

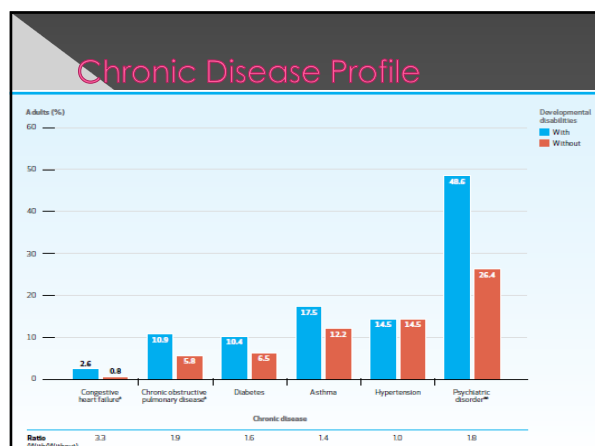
Co-Morbidities

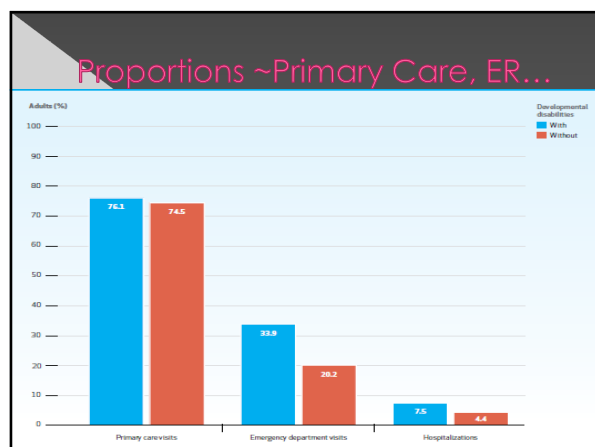
- ◉ Complicating factors (e.g. multiple & long-term medications, vulnerabilities)
- ◉ Undiagnosed / Untreated Dental, Hearing and Vision Impairment
- ◉ Live more sedentary lifestyles with poor nutrition.
- ◉ **4 - 6 times the rate of preventable deaths**

Chronic Health Issues

- ◉ Evidence to suggest a greater rate of:
 - > Dental caries & gingivitis
 - > High blood pressure, high cholesterol
 - > Other cardiovascular & respiratory diseases
 - > Obesity
 - > Diabetes
 - > Gastrointestinal Disorders, e.g. GERD, constipation
 - > Sensory impairments
 - > Mental health problems
- ◉ Possibly due to poor health prevention and promotion, lack of access to health programs/interventions, challenges due to their developmental disability







Leading Causes of Death due to Illness

General Population	People with Developmental Disability
1. Cancer	1. Respiratory diseases
2. Ischemic heart disease	2. Heart disease due to obesity, congenital malformations, side effects of neuroleptics
3. Cerebrovascular disease	3. Gastrointestinal diseases

Then of course there is...

DIAGNOSTIC OVERSHADOWING

Non-Psychiatric Health Problems among In-Patient Mental Health Patients with I/DD

- 198 subjects- specialized inpatient psych unit
 - Identified as Danger to self /others
 - Multi Discipline Assessments (primary care, psychiatry, neurology, psychology)
 - New diagnoses:
- 60% Constipation 38% GERD 17% Yeast Infection
15% UTI 10% Ear infection 10% Dental






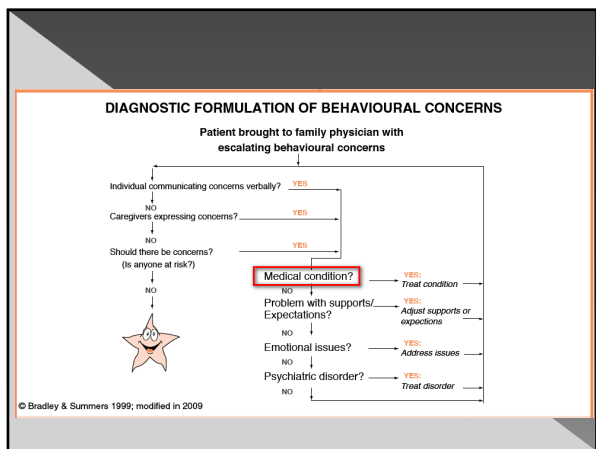
- 40% identified with medical problem as primary reason for admission.
- Significant correlation between the number of medical diagnosis and number of psychoactive medications & length of stay .
- Agitation related to a medication side effect was documented as a suspected cause of decompensation in a number of subjects.



Behavioral & Mental Health

- A Guide to Understanding Behavioral Problems & Emotional Concerns
- This guide aims to help identify the causes of behavioral problems, in order to plan for treatment and management, and prevent reoccurrence

A cartoon illustration of a person with a keyhole for a head, surrounded by various symbols like eyes, flowers, and the letter 'i'. The person is wearing an orange shirt with yellow cuffs. The background is yellow with scattered symbols including eyes, flowers, and the letter 'i'. There is some handwritten text on the left side of the person's head, which appears to be "What's going on in my mind?" and "What's going on in my heart?".



PART B: CAREGIVER SECTION		Name:
		DOB:
2.2: SUPPORT ISSUES		
Are there any problems in this patient's support system that may contribute to his/her basic needs not being met?		
Does this patient have a <input type="checkbox"/> hearing or <input type="checkbox"/> vision problem ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: If yes, what is in place to help him/her?
Does this patient have a communication problem ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: If yes, what is in place to help him/her?
Does this patient have a problem with sensory triggers ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: If yes, what is in place to help him/her?
If yes, do you think this patient's environment is <input type="checkbox"/> over-stimulating? <input type="checkbox"/> under-stimulating? or <input type="checkbox"/> just right for this patient?		
Does environment seem too physically demanding for this patient?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does this patient have enough opportunities for appropriate physical activities ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Does this patient have mobility problems or physical restrictions ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: If yes, what is in place to help him/her? If yes, does he/she receive physiotherapy?
Are there any supports or programs that might help this patient and which are not presently in place?		
<input type="checkbox"/> No <input type="checkbox"/> Yes: If yes, please describe:		
Caregiver comments:		

Today's Visit Tool

● Tool to help with optimizing limited time allotted for medical appointments

SECTION 1: Tools for General Issues in Primary Care

TODAY'S VISIT

Main Reason for Today's Visit is in the Physician or Nurse
(Do not check any of the boxes with an "X" and do not check more than one box)

☐ New illness or complaint from one or more body systems

☐ Being an updated evaluation, list of all medications being taken, and/or management plan for chronic condition

☐ New medical problem unrelated from the patient's

☐ A new medical problem related to the patient's

Up-to-date Medication List attached? ☐

<p>Name: _____ (last, first)</p> <p>Address: _____</p> <p>DOB (mm/yyyy): _____</p> <p>Health Card Number: _____</p> <p>Date of Visit: _____</p>	<p>Gender: _____</p>
--	-----------------------------

What is the main health problem the patient or DO or caregivers are concerned about? List any new symptoms. List possible contributing factors.

Circle or list other needs – e.g., prescription renewals, test results, forms to be filled out, appointment for annual exam:

Any Recent Changes or Stressors? ☐ No ☐ Yes
(e.g., self management, family stress or illness, changes in living or social environment)

Any recent visit to the dentist or other doctor? ☐ No ☐ Yes

Any recent medication changes or additions? ☐ No ☐ Yes

Antibiotic antibiotics, vaccine or medical treatment?

Caregiver Issues – little down to self doctor or nurse whether there are issues regarding caregiver fatigue or burden

Referred/Ref: _____ **Contacted:** _____ **Signature:** _____

INTERVIEWER AGREES TO COMPLETE, KEEP COPY FOR CHART, AND GIVE COPY TO THE PATIENT'S CAREGIVER

Assessment:

Physician's Diagnosis:

Treatment Plans including Medication Changes:

Advice to Patient and Caregiver:

Next Planned Visit / Follow-up: _____ **MO / RN Signature:** _____

MONITORING OF DAILY FUNCTIONS DURING THE PAST WEEK							
	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
ACTIVITY LEVEL (N, or)							
SLEEP Pattern and hours required (daytime and night)							
EATING/WEIGHT (N, or) Include total # of meals and if completed/day							
BOWEL ROUTINE (N, or C)							
MOOD/BEHAVIOUR (N, or) Describe if changed (e.g., agitated, withdrawn)							

Fill in chart using: N = Normal or usual for that person; ↓ = Decrease in amount, level or function; ↑ = Increase in amount, level or function
C = Constipation - a stool is passed less often than every two days or stools are hard and/or difficult or painful to pass, even if the person has stools every time per week.

Examples of Tools – Health Watch Tables

- Down Syndrome
- Fragile X Syndrome
- Prader-Willi Syndrome
- Smith-Magenis Syndrome
- 22q11.2 Deletion Syndrome
- FASD
- Autism



Down Syndrome HWT

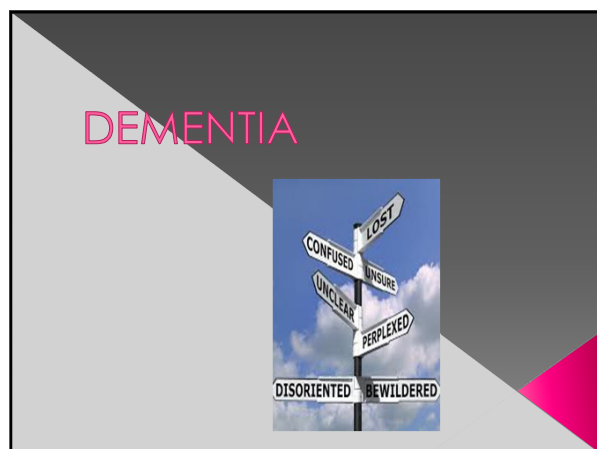
<http://www.surreyplace.on.ca/Documents/Down%20Syndrome.pdf>

Health Watch Table — Down Syndrome

Forster-Gibson and Berg 2011

CONSIDERATIONS	RECOMMENDATIONS
1. HEENT (HEAD, EYES, EARS, NOSE, THROAT)	
Children and Adults: Vision: ~ 15% have cataracts; ~ 20% - 70% have significant refractive errors 5% - 15% of adults have keratoconus Hearing: 50% - 80% have a hearing deficit	<input type="checkbox"/> Neonatally: refer immediately to an ophthalmologist if the red reflex is absent or if strabismus, nystagmus or poor vision is identified <input type="checkbox"/> Arrange ophthalmological assessment: first by 6 months for all; then every 1-2 years, with special attention to cataracts, keratoconus, and refractive errors <input type="checkbox"/> During childhood: screen vision annually with history and exam; refer as needed <input type="checkbox"/> Arrange auditory brainstem response (ABR) measurement by 3 months if newborn screening has not been done or if results were suspicious <input type="checkbox"/> During childhood: screen hearing annually with history and exam; review risks for frequently occurring serious otitis media <input type="checkbox"/> Undertake auditory testing: first at 9 - 12 months, then every 6 months up to 3 years, annually until adulthood, then every two years
2. DENTAL	
Children and Adults: tooth anomalies are common increased risk of periodontal disease in adults	<input type="checkbox"/> Undertake initial dental exam at 2 years, then every 6 months thereafter. Encourage proper dental hygiene. Refer to an orthodontist if needed <input type="checkbox"/> Undertake clinical exams every six months with referral, as appropriate
3. CARDIOVASCULAR	
Children: 30% - 60% have congenital heart defects (CHD)	<input type="checkbox"/> Newborn screening: Obtain an echocardiogram and refer to a cardiologist, even in the absence of physical findings <input type="checkbox"/> In children and adolescents: review cardiovascular history and assess for physical signs with specialist referral if indicated • Refer for an echocardiogram if not previously done • Undertake SBE prophylaxis as indicated by findings

Health Watch Table — Fragile X Syndrome <small>Forster-Gibson and Berg 2011</small>	
CONSIDERATIONS	RECOMMENDATIONS
1. HEENT (HEAD, EYES, EARS, NOSE, THROAT)	
Children: Vision: strabismus, refractive errors are common	<input type="checkbox"/> Undertake newborn vision and hearing screening and an auditory brainstem response (ABR)
Hearing: recurrent otitis media is common	<input type="checkbox"/> Refer for a comprehensive ophthalmologic examination by 4 years of age
Nose: sinusitis is common	<input type="checkbox"/> Visualize tympanic membranes at each visit
Adults: strabismus and refractive errors are common	<input type="checkbox"/> Undertake hearing and vision screening at each visit with particular attention to myopia and hearing loss
2. DENTAL	
Children and Adults: High arched palate and dental malocclusion are common	<input type="checkbox"/> Refer to a dentist for an annual exam
3. CARDIOVASCULAR	
Children: Mitral Valve Prolapse (MVP) is less common in children (~10%), but may develop during adolescence	<input type="checkbox"/> Auscultate for murmurs or clicks at each visit. If present, do an ECG and echocardiogram; refer to cardiologist, if indicated
Adults: MVP is common (~80%). Aortic root dilation usually is not progressive. Hypertension is common and exacerbated by anxiety	<input type="checkbox"/> Undertake an annual clinical exam. Based on findings, obtain an ECG and echocardiogram. Refer to cardiologist, as appropriate
	<input type="checkbox"/> Measure BP at each visit and at least annually
	<input type="checkbox"/> Treat hypertension when present
4. RESPIRATORY	
Children & Adults: Obstructive sleep apnea (OSA) may be due to enlarged adenoids, hypotonia or connective tissue dysplasia	<input type="checkbox"/> Ascertain a sleep history and assess for evidence of OSA
	<input type="checkbox"/> Obtain a sleep study as appropriate
5. GASTROINTESTINAL	
Children: In infants, feeding problems are common with recurrent emesis associated with Gastroesophageal Reflux Disease (GERD) in ~30% of infants	<input type="checkbox"/> Refer for assessment of GERD. Thickened liquids and upright positioning may be sufficient to manage GERD



DD Primary Care Guidelines - Dementia

31. Dementia is important to diagnose early especially in adults with Down syndrome who are at increased risk.¹⁸ Diagnosis might be missed because changes in emotion, social behaviour, or motivation can be gradual and subtle. A baseline of functioning against which to measure changes is needed.

Differentiating dementia from depression and delirium can be especially challenging.¹⁹

a. For patients at risk of dementia, assess or refer for psychological testing to establish a baseline of cognitive, adaptive, and communicative functioning. Monitor with appropriate tools.¹⁹

b. Educate family and other care providers about early signs of dementia. When signs are present, investigate for potential reversible causes of dementia.

c. Consider referral to the appropriate specialist (ie, psychiatrist, neurologist) if it is unclear whether symptoms and behaviour are due to emotional disturbance, psychiatric disorder, or dementia.¹⁹

Guideline 31: "Dementia is important to diagnose early, especially in adults with Down syndrome who are at increased risk. Diagnosis might be missed because changes in emotion, social behaviour, or motivation can be gradual and subtle. A baseline of functioning against which to measure changes is needed..." "For patients at risk of dementia, assess or refer for psychological testing to establish a baseline of cognitive adaptive, and communicative functioning. Monitor with appropriate

Down Syndrome HWT

<http://www.surreyplace.on.ca/Documents/Down%20Syndrome.pdf>


Health Watch Table – Down Syndrome

CONSIDERATIONS	RECOMMENDATIONS
9. NEUROLOGICAL	
Children: Epilepsy in up to 22%	<input type="checkbox"/> Take careful neurological history with particular attention to seizures (infantile spasms or tonic-clonic-type) <input type="checkbox"/> Arrange an EEG and refer to a neurologist
Adults: Dementia is frequent and occurs earlier: 11%: 40 – 49 y. 77%: 60 – 69 y. Up to 75% with dementia have seizures with frequency increasing with age	<input type="checkbox"/> Obtain a neuropsychiatric history at every visit with particular attention to change in behaviour, loss of function/activities of daily living, and new onset seizures <input type="checkbox"/> If functional decline and/or signs/symptoms of dementia, use history, exam, and blood work to check for other conditions and treatable causes (e.g., hearing/vision deficits, obstructive sleep apnea, hypothyroidism, chronic pain, medication side effects, depression, menopause, low folic acid/vitamin B12) <input type="checkbox"/> For possible seizures, arrange an EEG and refer to a neurologist

"Adults: Dementia is frequent and occurs earlier: 11 % 40-49 y, 77% 60-69 y..." "If functional decline... use history, exam, and blood work to check for other conditions... (e.g. hearing/vision deficits, obstructive sleep apnea, hypothyroidism, chronic pain, medication side effects, depression, menopause, low folic acid/vitamin B12)"

**Behaviour is Communication
– Rule Out Medical Causes First**

- Important for a doctor to rule out other medical conditions that could cause changes in behaviour, to avoid misdiagnosis of dementia
- Other disorders that can cause loss of memory, confusion, attention deficit or symptoms similar to dementia include:
 - depression, chronic pain, sleep apnea, anaemia, malnutrition or vitamin deficiencies, side effects of medication, diabetes, kidney or liver disease, thyroid abnormalities, heart problems, etc.



CRITICAL !

1ST...

**ELIMINATE OTHER
CAUSES FOR
BEHAVIOUR CHANGE**

Dementia

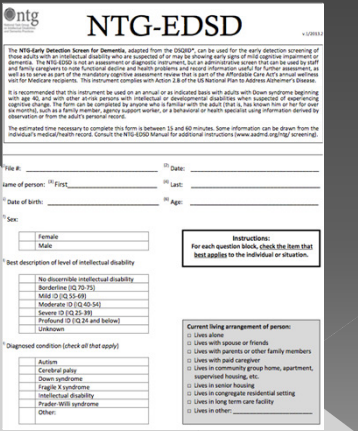
- Behaviour changes often attributed to dementia have other causes
 - > Physical loss (falls, gait changes)
 - > Sensory impairment
 - > Medical problems (delirium)
 - > Adverse drug reactions
 - > pain

Tools...



- NTG-EDSD (NTG-Early Detection Screen for Dementia)

NTG-Early Detection Screen for Dementia

<http://aadmd.org/sites/default/files/NTG-EDSD-Final.pdf>



ANNUAL PHYSICALS



© 2004 by M. F. F.
M. F. F. COMICS

YES, I DID HAVE MY MAMMOGRAM TODAY... WHY DO YOU ASK?

© 2004 by M. F. F.
M. F. F. COMICS

Preventative Care Checklist

Most Common Cancers

Men

- ◉ Prostate
- ◉ Bowel (colorectal)
- ◉ Melanoma
- ◉ Lung

Women

- ◉ Breast
- ◉ Bowel (colorectal)
- ◉ Melanoma
- ◉ Lung

Within Our Control...

- ◉ 1/3 cancer deaths in US linked to diet and physical activity
- ◉ Obesity affect people with I/DD at very high rates

Why???

- ◉ Lack of healthy choices
- ◉ Difficulty swallowing
- ◉ Medication
- ◉ Physical limitations
- ◉ Pain
- ◉ Accessibility
- ◉ Lack of resources

Risk Factors – Colorectal

- ◉ Diet (high in red meat & processed meats)
- ◉ Lack of exercise
- ◉ Weight
- ◉ Smoking
- ◉ Heavy alcohol use
- ◉ Age >50
- ◉ Other bowel diseases
- ◉ Family history



Lower the Risk

- ◉ Enjoy a diet rich in fruits, vegetables, whole grains
- ◉ Increase daily activity
- ◉ Maintain healthy weight
- ◉ Quit smoking
- ◉ Drink in moderation
- ◉ Know the family history

Nutrition

- ◉ Fruits and Vegetables (Surprise!)
 - > Limit sauces and dips
 - > Use whole fruits and veggies vs juices
- ◉ Limit processed meat (bacon, sausage, hot dogs, luncheon meats)
- ◉ Choose poultry or fish vs red meat
 - > choose lean cuts of red meat
- ◉ Bake, broil or poach
- ◉ Whole grains
- ◉ Limit refined sugars

Exercise!!! For the body...

- ◉ 150 minutes moderate intensity exercise weekly
 - > walking, dancing, leisurely bicycling, skating
- ◉ 75 minutes vigorous intensity exercise
 - > Jogging/running, weight training, areobics
- ◉ Limit sedentary activities
 - > Sitting, lying down, TV, video games



EXERCISE!! For the mind...

"Aerobic activity is the single most effective treatment for depression, anxiety and PTSD" ~ David Pitonyak

Risk Factors - Breast

- ◉ Gender (female)
- ◉ Aging
- ◉ Genetics
- ◉ Heredity
- ◉ Dense breast tissue
- ◉ Medication (birth control, HRT)
- ◉ Weight
- ◉ Exercise



Due Diligence



Communication Strategies

- ◉ Carefully consider the person's ability to understand
- ◉ Allow plenty of time
- ◉ No assumptions
- ◉ Picture cues and books
- ◉ Provide honest and simple answers
- ◉ Concrete communication vs abstract

E-books – Surrey Place

My Health Booklet Series

- ◉ Breast health
- ◉ Periods
- ◉ Menopause
- ◉ Pelvic exams
- ◉ Colonoscopy
- ◉ Men's health

http://www.surreyplace.on.ca/resources-publications_submenu?id=128

Books Beyond Words

- ◉ Series of picture books
- ◉ Counselling tools
 - Includes text and additional info for caregivers
- ◉ "Looking After My Breasts"
- ◉ Deals with self-exams, medical exam, mammograms

Policy Work



Bowel Health

- ◉ Gastrointestinal Problems are 3rd leading cause of death for people with I/DD
- ◉ Constipation!!!










Prevention...

"Preventing constipation is easier than treating it."

- ◉ Routine
- ◉ Define constipation
- ◉ Water
- ◉ Fruits & Veggies

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Caregiver Health Assessment Tool

**CAREGIVER HEALTH ASSESSMENT
FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES**

Person's Name: _____

Like to be called: _____

Date of Birth: ____/____/____

Address: _____

City: _____ **Postal Code:** _____

Telephone Number: _____

How to Fill Out and Use This Form

This health information helps the caregiver to know more about the person with a developmental disability and their health problems. This information can also be helpful to the family physician or primary care provider.

This health information is **intended to be shared** with the person and their care providers. **LEGIBLE, KEEP IT CONFIDENTIAL!**

The person with the developmental disability placed on this form with the help of family members, caregivers, and medical records. Call us if you need more information.

- If it is not filled out by a caregiver, call us at 1-800-455-2000.
- The form can be used at home, and at many meetings. It can be revised as needed when changes occur.

CONTACT INFORMATION	
CONTACT	NAME AND ADDRESS
Current Living Arrangement <input type="checkbox"/> Independent - Other _____ <input type="checkbox"/> Subsidized Dwelling <input type="checkbox"/> Waiver or _____ <input type="checkbox"/> Power of Attorney for Personal Care Next of Kin Relationship _____ Family/ Significant Others/ Children Lead Agency _____	(Indicate by P for Home, H for Hotel, B for Boarding)

PART I. BACKGROUND INFORMATION

Person's Developmental Disability: (If Autism Spectrum Disorder - ASD diagnosed, please include) _____

Known cause of syndrome? _____ Unknown

Ever had a Genetic assessment? ☐ No ☐ Unsure ☐ Yes Date ____/____/____ Day on Test ☐ No ☐ Yes

Ever had a Psychological assessment? ☐ No ☐ Unsure ☐ Yes Date ____/____/____ Day on Test ☐ No ☐ Yes

Continued...

Carer Health Assessment Tool

- Part II Head to Toe Review
- Head

PART II: HEAD TO TOE REVIEW		YES	NO	DONT KNOW	CHANGE - just if
<i>If you are unsure of the answer please check "Don't know" rather than guessing</i>					
1. EYES, EARS, & TEETH / MOUTH / THROAT Does this person					
YES:	LAST EYE DOCTOR APPOINTMENT: _____				
RESULT: _____					
<ul style="list-style-type: none"> • Wear glasses? • Have any signs of vision problems? <ul style="list-style-type: none"> • Ever have drainage or drainage from their eyes? • Squint or rub their eyes? • Other _____ 					
EARS:	LAST HEARING TEST APPOINTMENT: _____				
RESULT: _____					
<ul style="list-style-type: none"> • Wear a hearing aid? • Have any signs of hearing problems? • Ever have earwax problems? • Other ear problems (e.g., ear infections, drainage from ears) if yes, how often? _____ 					
DENTAL:	LAST DENTIST APPOINTMENT (dd/mm/yyyy): _____				
RESULT: _____					
<ul style="list-style-type: none"> • Have own teeth? • Have false teeth or partial dentures? • Have no teeth and no dentures? • Have problems with teeth? <ul style="list-style-type: none"> • Have toothaches? • Have gum problems? (e.g., swollen gums, or bleeding when brushing?) • Have poor oral hygiene? (brushing <2x/day, not flossing) • Have poor denture hygiene? • Refuse to go or hasn't been to the dentist regularly? • Need sedation for dental procedures? last appointment: _____ 					

COREGIVER HEALTH ASSESSMENT TOOL		PATIENT HEALTH ASSESSMENT TOOL	
<p>Part I Head to Toe Review</p> <p>Chest & Abdomen</p>	<p>1. HEART (CARDIAC SYSTEM) Does the person _____</p> <ul style="list-style-type: none"> Have high blood pressure (hypertension)? <input type="checkbox"/> If yes, does the person take medications for high blood pressure? <input type="checkbox"/> Have heart disease? <input type="checkbox"/> If yes, what kind of heart problem does he/she have? _____ Ever have problems with heart "racing" or missing a beat? <input type="checkbox"/> Ever experience pain in chest, left arm or jaw? <input type="checkbox"/> Have swelling of the feet or ankles? <input type="checkbox"/> Get short of breath when lying in bed? <input type="checkbox"/> Ever get blue skin (e.g., fingertips, lips, toes)? <input type="checkbox"/> Other _____ 		
	<p>3. LUNGS/BREATHING (RESPIRATORY SYSTEM) Does the person _____</p> <ul style="list-style-type: none"> Have asthma? <input type="checkbox"/> If yes, are they on medications (e.g., inhalers)? <input type="checkbox"/> Is the person's asthma well controlled (e.g., no emergency department visits)? <input type="checkbox"/> Have COPD (chronic obstructive pulmonary disease and emphysema)? <input type="checkbox"/> Get frequent Colds, C pneumonia, C bronchitis? <input type="checkbox"/> Have a chronic cough or cough that doesn't go away? <input type="checkbox"/> Have shortness of breath, or wheezing? <input type="checkbox"/> Cough up mucus or blood? <input type="checkbox"/> If yes, color and describe: _____ Other _____ 		
	<p>4. STOMACH AND BOWEL (GASTROINTESTINAL) Does the person _____</p> <ul style="list-style-type: none"> Have problems with chewing? <input type="checkbox"/> Have problems with swallowing? (chokes, pain or injury during or after eating or drinking) <input type="checkbox"/> Have a □ weight gain or □ weight loss more than 10 lbs in past year <ul style="list-style-type: none"> If yes, □ intentional □ unplanned (Red flag: Weight Chart) Have problems with eating or with stomach? <input type="checkbox"/> <ul style="list-style-type: none"> Get □ too much or □ too little Drink □ too much or □ too little Have poor nutrition - food _____ Have PICA (eats non-food material e.g., paper, dirt)? <input type="checkbox"/> Have a special diet - specify: _____ Vomits or regurgitates _____ Have heartburn _____ Have pain or discomfort after eating _____ 		

Caregiver Health Assessment Tool

- Part II Head to Toe Review
- Musculoskeletal, Thyroid & Hormones

6. MUSCLES & JOINTS (focus on any changes in mobility/ walking) Does this person:	(Consider Pain Record)			
• Have <input type="checkbox"/> joint pain or <input type="checkbox"/> back pain? If yes, location: _____	▲	▲	▲	▲
• Have <input type="checkbox"/> muscle pain or <input type="checkbox"/> stiffness or <input type="checkbox"/> joint swelling?	▲	▲	▲	▲
• If yes, location: _____				
• Have a history of broken bones? If yes: _____	▲	▲	▲	▲
Location: _____ Date: ____/____/____				
Location: _____ Date: ____/____/____				
• Have a diagnosis of osteoporosis (brittle bones)?	▲	▲	▲	▲
• If yes, Date of Diagnosis (dd/mm/yy): ____/____/____				
• Have mobility problems? If yes, describe: _____	▲	▲	▲	▲
• Use devices like special shoes or splints?	▲	▲	▲	▲
• Have protective devices? (e.g., head gear for head banging or frequent falls)	▲	▲	▲	▲
• If yes, describe: _____				

Caregiver Health Assessment Tool

- Part II Head to Toe Review
- Nervous system/neurological
 - Guideline 18 Epilepsy

7. NERVOUS SYSTEM (NEUROLOGICAL) Does this person	(*Use seizure record and Action Plan/Protocol)			
• Have epileptic seizures?	▲	▲	▲	▲
• Have recent changes in seizure appearance?	▲	▲	▲	▲
Describe: _____				
• Faint?	▲	▲	▲	▲
• Complaint of headaches or dizziness?	▲	▲	▲	▲
• If yes, how often? _____				
• Seem unsteady when walking or suffered falls?	▲	▲	▲	▲
Last fall date: ____/____/____				
• Have weakness in their arms or legs or tics?	▲	▲	▲	▲
• Have shaky or uncontrollable movements?	▲	▲	▲	▲

Caregiver Health Assessment Tool

- Part II Head to Toe Review
- Urinary, Sexual/Men's/Women's Health

9. SEXUAL HEALTH Is this person				
• Sexually active now or in the past?	▲	▲	▲	▲
• If active, do they use contraceptives? If yes, name (e.g., condom, DepoProvera, oral contraceptive pills)	▲	▲	▲	▲
• If active, do they use Sexual Transmitted Infection (STI) prevention?	▲	▲	▲	▲
If yes, name (e.g., condom) _____				
• Please list any known current or past STIs _____	▲	▲	▲	▲
• Exhibiting any sexually inappropriate behaviours? (e.g., touching, etc.)	▲	▲	▲	▲
• Does this person have any masturbation issues?	▲	▲	▲	▲
<input type="checkbox"/> public <input type="checkbox"/> private <input type="checkbox"/> tissue damage				
<input type="checkbox"/> interferes with daily life				
10. WOMEN'S HEALTH Does this person	Consider Menstrual Record			
• Menstruate?	▲	▲	▲	▲
<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Controlled with Medication				
• Have any physical discomfort with her menstrual periods?	▲	▲	▲	▲
• Have any behavioural changes with her menstrual cycle?	▲	▲	▲	▲
• Ever been pregnant? If yes, how many times? _____	▲	▲	▲	▲
If yes, how many children? _____ When? _____				

Caregiver Health Assessment Tool

☒ Appendices
 > Annual Health Review Summary & Doctor's Appointment

This page can be helpful for the Yearly Person-Directed Plan Meeting, and for the annual physical with the doctor. For other doctor's appointments, use Today's Visit Form.

In the past year, has this person's **ability to function** gotten **better (↑)** or **worse (↓)** in any of these areas?

<input type="checkbox"/> self care (eating, toileting, dressing, hygiene) <input type="checkbox"/> movement (standing, walking, coordination) <input type="checkbox"/> bowel / bladder continence <input type="checkbox"/> memory, ability to understand Other (describe): _____	<input type="checkbox"/> level of interest in work or play <input type="checkbox"/> social involvement with friends, family <input type="checkbox"/> communication <input type="checkbox"/> need for supervision or direction
--	--

If the person's ability to function has gotten worse, when did it start? _____

Are there any symptoms or behaviours that happened with this change? _____

Caregiver Tools – Sleep Chart

