

# Health Check Templates (CPX Forms)

## Example #2 OSCAR

### IDD Health Check<sup>1</sup>

For adults with an intellectual and developmental disability (IDD)<sup>2</sup>

Patient Name:

Date of Birth:

Address:

Phone:

For example: preferred time of day, ability to tolerate time in the waiting room; special positioning for exam; mobility and transfer needs, need for electric bed; sensory integration issues; triggers, e.g., noise, lighting; may require extra staffing; method of expressive communication; preferred receptive communication, e.g., pictures, simple explanations, sign language

### Review Background and Update Cumulative Patient Profile

Tick the boxes ("done" or "not done") to indicate if relevant information was entered / updated / completed

<u>Update the "Ongoing Concerns" field</u>	Done	Not done	<u>Update the "Alert" field (Register)</u>		
Communication <sup>3</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Substitute decision maker		
Accommodations (relevant to RN/MD) <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Contact person for appointments		
Capacity <sup>5</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Accommodations (relevant to reception) <sup>6</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Transition or Advanced Care Planning <sup>7</sup>	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Update the "Medical History" field</u>			<u>Update the other Cumulative Patient Profile fields</u>		
Etiology of IDD <sup>8</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Disease Registry- add code 3 159	<input type="checkbox"/>	<input type="checkbox"/>
Past Genetic Assessment <sup>10</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Preventions <sup>9</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Past Psychology/Functional Assess <sup>11</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Social history <sup>11</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Level of intellectual disability <sup>14</sup>	<input type="checkbox"/>	<input type="checkbox"/>	Reminders <sup>12</sup>	<input type="checkbox"/>	<input type="checkbox"/>
			Prescriptions <sup>13</sup>	<input type="checkbox"/>	<input type="checkbox"/>
			Family history <sup>15</sup>	<input type="checkbox"/>	<input type="checkbox"/>

Collateral information / coordination with other services<sup>17</sup> (if applicable and available, review and scan into EMR)

Caregivers/ patients self-reported history form<sup>18</sup> requested / reviewed?  yes  no

Health Links' Comprehensive Care Plan<sup>19</sup> requested / reviewed?  yes  no

Developmental Service Agency support/care plan<sup>20</sup> requested / reviewed?  yes  no

### Current Concerns: (Use "Extra Comments" box at the end of form for overflow)

To obtain a copy of this fully annotated Health Check template, please contact Dr. Ian Casson, at:  
[ian.casson@dfm.queensu.ca](mailto:ian.casson@dfm.queensu.ca)

### Functional Inquiry<sup>21</sup> (Enter remarks by # in text box below)

	Problem	No Problem		Problem	No Problem
1. Constitutional Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	10. Neurology <sup>31</sup>	<input type="checkbox"/>	<input type="checkbox"/>
2. HEENT	<input type="checkbox"/>	<input type="checkbox"/>	11. Endocrinology <sup>32</sup>	<input type="checkbox"/>	<input type="checkbox"/>
- last hearing assessment <sup>22</sup>	date (yy): _____		12. Behavioural Changes <sup>33</sup>	<input type="checkbox"/>	<input type="checkbox"/>
- last vision assessment <sup>23</sup>	date (yy): _____		13. Pain <sup>34</sup>	<input type="checkbox"/>	<input type="checkbox"/>
- last dental care <sup>24</sup>	date (yy): _____		14. Abuse, Neglect, Exploitation <sup>35</sup>	<input type="checkbox"/>	<input type="checkbox"/>
3. Respiratory <sup>25</sup>	<input type="checkbox"/>	<input type="checkbox"/>	15. Mental Health <sup>36</sup>	<input type="checkbox"/>	<input type="checkbox"/>
4. CVS <sup>26</sup>	<input type="checkbox"/>	<input type="checkbox"/>	16. Nutrition <sup>37</sup>	<input type="checkbox"/>	<input type="checkbox"/>
5. GI <sup>27</sup>	<input type="checkbox"/>	<input type="checkbox"/>	17. Activity Level <sup>38</sup>	<input type="checkbox"/>	<input type="checkbox"/>
6. GU <sup>28</sup>	<input type="checkbox"/>	<input type="checkbox"/>	18. Smoking, Alcohol, Drugs	<input type="checkbox"/>	<input type="checkbox"/>
7. Sexual Issues <sup>29</sup>	<input type="checkbox"/>	<input type="checkbox"/>	19. Safety, Seat Belts, Bike Helmets <sup>39</sup>	<input type="checkbox"/>	<input type="checkbox"/>
8. Musculoskeletal <sup>30</sup>	<input type="checkbox"/>	<input type="checkbox"/>	20. Sleep <sup>40</sup>	<input type="checkbox"/>	<input type="checkbox"/>
9. Skin	<input type="checkbox"/>	<input type="checkbox"/>	21. Other	<input type="checkbox"/>	<input type="checkbox"/>

Remarks for Functional Inquiry (Enter information by # above. Use "Extra Comments" box at the end of form for overflow)

In the EMR, there are annotations that pop up to explain the importance of the items on the form to the health care of adults with DD, along with links to relevant clinical tools.

