The C21st Health Check – II is purpose designed for use by additionally trained nurses, with adults with learning disabilities.

It is advisable that the adult with learning disabilities has a relative, support worker, friend or advocate supporting her / him during the health check.

The nurse should expand, rephrase and clarify prompts as required, in order to fully explore each item to be rated.

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PART I

REVIEW OF
GENERAL PRACTITIONER CASE-NOTES

(Please check computer and paper records)
A. PERSONAL INFORMATION

Forename ........................................................................................................................................
Surname ........................................................................................................................................
Date of birth  [   ][   ] / [   ][   ] / [   ][   ]

Address 1 (flat number, house number, street, district) .................................................................
Address 2 (town, city) ...................................................................................................................
Address 3 (post code) ....................................................................................................................

General Practitioner ....................................................................................................................
Practice ...........................................................................................................................................
Telephone number ........................................................................................................................
Address 1 (flat number, house number, street, district) .................................................................
Address 2 (town, city) ...................................................................................................................
Address 3 (post code) ....................................................................................................................

Date of review of GP notes (date / month / year)  [   ][   ] / [   ][   ] / [   ][   ]

Review completed by (provide name, and tick grade) .................................................................
- LD nurse I  1 [   ]
- LD nurse H  2 [   ]
- LD nurse G  3 [   ]
- Primary Care nurse G  4 [   ]
- LD nurse E  5 [   ]
- Doctor  6 [   ]
- Other & specify ......................................................................................................................... [   ]

1. List the person’s telephone number, if in the notes .................................................................

2. Will wheelchair scales be needed?  YES / NO

3. Date of first case-note entry / first registration with any GP?  [   ][   ] / [   ][   ] / [   ][   ]

4. Date of first registering with this practice  [   ][   ] / [   ][   ] / [   ][   ]
B. PROCEDURES AND INVESTIGATIONS

List the tests, investigations or procedures undertaken, with dates. If a test is abnormal, specifically check back to see if there has previously been a normal result, and also list this, with its date. Also check the correspondence from secondary care that is filed in the GP notes.

<table>
<thead>
<tr>
<th>Test</th>
<th>Date of most recent test</th>
<th>Results of most recent test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical smear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus course and booster <em>(needs 5 injections in total)</em></td>
<td></td>
<td>State if the person has had 5 in total during their life</td>
</tr>
<tr>
<td>Polio course and booster <em>(needs 5 in total during life)</em></td>
<td></td>
<td>State if the person has had 5 in total during their life</td>
</tr>
<tr>
<td>Hepatitis B course and booster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu jab</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>ECG <em>(also state where it was done)</em></td>
<td></td>
<td>Where was it done?</td>
</tr>
<tr>
<td>Exercise ECG <em>(stress test)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Echocardiogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine (infection, or microalbumen, protein)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e.g. FEV1, spirometry)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. BLOOD TESTS

List the **blood tests** undertaken, with dates. Where there is more than one test of a certain type, **list the most recent one**. If a test result is abnormal, specifically check to see if there has previously been a normal result, and also list this with its date. Check blood forms, and also the correspondence from secondary care that is filed in the GP notes and the computer records.

<table>
<thead>
<tr>
<th>Blood test</th>
<th>Dates of tests</th>
<th>List any abnormalities on this test / drug level, or tick if it’s normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBC</td>
<td></td>
<td></td>
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<tr>
<td>Blood film</td>
<td></td>
<td></td>
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<tr>
<td>B12 / folate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESR / CRP (state the actual result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serum iron / TIBC / ferritin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U&amp;Es / estimated glomerular filtration rate / eGFR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LFTs, calcium, phosphate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol (state the actual result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clotting screen / Prothombin / PT / PTT / INR</td>
<td></td>
<td></td>
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<tr>
<td>TFTs (Free T&lt;sub&gt;4&lt;/sub&gt; / TSH)</td>
<td></td>
<td></td>
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<tr>
<td>Glucose (BGL / BSL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c (state the actual result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood test</td>
<td>Dates of tests</td>
<td>List any abnormalities on this test / drug level, or tick if it’s normal</td>
</tr>
<tr>
<td>------------------</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Lipids</td>
<td></td>
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<tr>
<td>PSA</td>
<td></td>
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<tr>
<td>Trough blood levels (<em>state the actual result</em>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td></td>
<td></td>
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<tr>
<td>Phenytoin</td>
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<td></td>
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<tr>
<td>Phenobarbitone</td>
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<tr>
<td>Lithium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warfarin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digoxin</td>
<td></td>
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<tr>
<td>Theophyline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

For abnormal blood tests, has this test previously been normal i.e. when did the test become abnormal?

........................................................................................................................................
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8
D. DEVELOPMENT AND ABILITY

1. Is there any documented cause of the person’s learning disabilities? (Please tick)
   - Unknown, despite investigation: 1 [ ]
   - Unknown, and no record of it being fully investigated: 88 [ ]
   - Down’s syndrome: 2 [ ]
   - Tuberous sclerosis: 3 [ ]
   - Eclampsia / ante-partum haemorrhage / complications of pregnancy: 4 [ ]
   - “Birth injury”: 5 [ ]
   - Meningitis / encephalitis: 6 [ ]
   - Fragile X syndrome: 7 [ ]
   - Head injury: 8 [ ]
   - Brain tumour: 9 [ ]
   - Hydrocephalus: 10 [ ]
   - Microcephaly: 11 [ ]
   - Phenylketonuria (PKU): 12 [ ]
   - Prader-Willi syndrome: 13 [ ]
   - Smith-Magenis syndrome: 14 [ ]
   - Rett syndrome: 15 [ ]
   - Congenital rubella: 16 [ ]
   - Other & specify: ________________________________ [ ]

2. Is there any documented testing of the person’s ability level in the last 10 years? (Please tick)
   - Test type: __________________________________________
   - Date of test / person’s age: ____________________________
   - Who completed the test: ________________________________
   - Result (Please tick)
     - Mild learning disabilities (IQ = 50 – 69; mental ability = 9 - 12 years): 1 [ ]
     - Moderate learning disabilities (IQ = 35 – 49; mental ability = 6 - 9 years): 2 [ ]
     - Severe learning disabilities (IQ = 20 – 34; mental ability = 3 - 6 years): 3 [ ]
     - Profound learning disabilities (IQ < 20; mental ability = 0 -3 years): 4 [ ]
     - No record of testing in last 10 years: 8 [ ]
     - Person does not have learning disabilities: 9 [ ]
E. GENERAL HEALTH

1. **Drugs** currently prescribed, with dose and frequency they are taken (e.g. twice a day), and the date they were commenced (*include repeat medication and acute prescriptions for drugs that are currently being taken*)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Form (e.g. tables, liquid)</th>
<th>Start date</th>
<th>Reason for prescription</th>
<th>Date this drug was last reviewed</th>
</tr>
</thead>
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</table>
2. If the person takes **risperidone or olanzapine**, is there a record of them having been tested for **diabetes** (blood or urine glucose test) in last 15 months
   - No 0 [  ]
   - Yes 1 [  ]

3. If the person takes inhaled medication, date of the most recent record of **inhaled technique** being checked?
   - Person does not take inhaled medication 0 [  ]

4. Date of most recent record of **FEV1**
   - There is no FEV1 record 0 [  ]

5. Previous **operations**.

<table>
<thead>
<tr>
<th>Operation type</th>
<th>Date</th>
<th>Reason</th>
<th>Outcome</th>
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6. Is there an **up – to – date clinical summary** in the casenotes?
   - No 0 [  ]
   - Yes 1 [  ]

7. Is there a **comprehensive care plan** in the notes?
   - No 0 [  ]
   - Yes 1 [  ]
8. Previous / current **health problems**. *(State diagnosis / type of illness; otherwise list possible diagnosis reported in notes or list symptoms.)*

<table>
<thead>
<tr>
<th>Diagnosis / health problem</th>
<th>Date of first documentation</th>
<th>Outcome</th>
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<tr>
<td>Diagnosis / health problem</td>
<td>Date of first documentation</td>
<td>Outcome</td>
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</tbody>
</table>
9. Is the person recorded as having **asthma**?

No ➤ 0 [   ]

Yes ➤ 1 [   ]

If YES, has **peak flow** been measured on several occasions?

No ➤ 0 [   ]

Yes ➤ 1 [   ]

If YES, do some of the peak flow measurements have a difference between them of 60 l/min or more (i.e. different peak flows on different days, or an improvement immediately after taking an inhaler)

No ➤ 0 [   ]

Yes ➤ 1 [   ]

If YES, date of the last recorded **asthma review** which included all of these items:

  - Whether the person has had difficulty sleeping because of asthma symptoms (including cough) ➤ [   ]
  - Whether the person has had their usual asthma symptoms during the day (cough, wheeze, chest tightness, or breathlessness) ➤ [   ]
  - Whether the person’s asthma has interfered with their usual activities e.g. housework ➤ [   ]
  - Peak flow measurement ➤ [   ]
  - An assessment of inhaler technique ➤ [   ]
  - Consideration given to a personalized asthma plan ➤ [   ]
    - No, not all of these ➤ [   ]
    - Yes, all of these ➤ [   ]

If YES, date of most recent review ➤ [   ] [   ] / [   ] [   ] / [   ] [   ] [   ] [   ]

10. Is the person recorded as having **epilepsy**?

No ➤ 0 [   ]

Yes ➤ 1 [   ]

If YES, date of the most recent review of **seizure frequency**?

[   ] [   ] / [   ] [   ] / [   ] [   ] [   ] [   ]

If YES, date of the most recent record of **anti epileptic drug review**

[   ] [   ] / [   ] [   ] / [   ] [   ] [   ] [   ]

There is no record of an anti epileptic drug review ➤ 0 [   ]
11. Is the person recorded as having diabetes?

No [ ]
Yes, insulin dependent [ ]
Yes, drug or dietary management [ ]
IF YES, date of the person’s last diabetes drug review? [ ]
There is no record of anti-diabetic drugs having ever been checked [ ]
IF YES, date of the most recent record of retinal screening [ ]
There is no record of this having been checked [ ]
IF YES, date of the most recent record of peripheral pulses having been checked [ ]
There is no record of them having been checked [ ]
IF YES, date of the most recent record of neuropathy testing (sensation and vibration) in the previous 15 months? [ ]
There is no record of neuropathy testing [ ]

12. Does the person have any of the following now or in the past?

Coronary heart disease, (angina, myocardial infarction, heart attack) [ ]
Heart failure [ ]
Stroke or transient ischaemic attack (CVA) [ ]
Hypertension [ ]
Chronic obstructive pulmonary disease [ ]
Psychosis (schizophrenia, schizoaffective disorder or bipolar affective disorder) [ ]
Dementia [ ]
Atrial fibrillation [ ]
Cancer [ ]
Depression [ ]
Palliative care needs [ ]
Chronic kidney failure [ ]

13. What was the person’s last recorded blood pressure result? [ ]

14. Date of the person’s last recorded blood pressure? [ ]
There is no record of blood pressure having ever been checked [ ]
15. What is the person’s last recorded body mass index (BMI)? [ ][ ][ ][ ]

16. **Date** of the person’s last recorded BMI? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of BMI having ever been checked 0 [ ]

17. Date if the person’s last recorded smoking status? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of smoking status 0 [ ]

18. For smokers, date of the most recent record of smoking cessation advice having been given, or referral to a specialist service offered? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of smoking cessation advice or the offer of a referral 0 [ ]
   The person is recorded as a non-smoker 1 [ ]

19. Date of most recent record of screening for depression with screening questions? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of screening for depression 0 [ ]
   Person in already receiving treatment for depression 1 [ ]

20. Date of the most recent record of alcohol use? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of alcohol use 0 [ ]

21. Date of the most recent record of illicit drug use? [ ][ ][ ] / [ ][ ][ ] / [ ][ ][ ]
   There is no record of whether illicit drugs are used 0 [ ]

22. Is there a record that the person has refused to attend any health reviews, having been invited on at least three occasions during the previous 12 months?
   No 0 [ ]
   Yes & specify …………………………………………………………………………………………… 1 [ ]

23. Is there a record that the person did not agree to have any advised investigation or treatment?
   No 0 [ ]
   Yes & specify …………………………………………………………………………………………… 1 [ ]
F. SECONDARY HEALTH CARE SERVICES

1. List any **secondary care specialties** that the person has been *referred to* and is waiting for an appointment.

<table>
<thead>
<tr>
<th>Name of secondary care specialty / doctor</th>
<th>Date the GP made referral</th>
<th>For which condition</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

2. **Secondary care specialties** that the person has *attended* in the last 5 year period, and whether this is ongoing or completed. *(Check correspondence from secondary care as well as GP entries.)*

<table>
<thead>
<tr>
<th>Name of secondary care specialty / doctor</th>
<th>For which condition</th>
<th>Ongoing or completed?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

3. Each **hospital admission** to secondary care specialties the person has had during the last 12 months, and duration of stay *(include the date of admission and date of discharge in the duration)*. *(Check correspondence from secondary care for discharge summaries.)*

<table>
<thead>
<tr>
<th>Name of secondary care specialty</th>
<th>For which condition</th>
<th>Duration of admission</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
4. Other **non-medical contacts** (including e.g. nurses, PAMS, audiology) or recommended contacts / resources in the last 12 months, and state whether ongoing or completed. *For each professional, indicate whether they work from the LD Service / Generic Secondary Service / Not Applicable / Not Known*

<table>
<thead>
<tr>
<th>Professional</th>
<th>Type of service (LD / Generic)</th>
<th>Ongoing or completed?</th>
</tr>
</thead>
<tbody>
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**G. ADULTS WITH INCAPACITY (SCOTLAND) ACT, 2000**

1. **Is there any record of** whether the person does, or does not have decision-making **capacity to consent** to, or refuse, each of their prescriptions / treatments? *(Check certificates and case-note entries.)*

- Yes, assessment of capacity has been recorded for each prescription / treatment  
  1 [ ]
- Incomplete or unclear mention for specific prescription / treatment(s)  
  2 [ ]
- No  
  3 [ ]
- A blanket statement is recorded (e.g. “any medical or dental treatment”), rather than a statement recorded for each prescription / treatment  
  4 [ ]
- Incomplete or unclear mention of overall prescriptions / treatments  
  5 [ ]
- Partially; comment on capacity has been recorded for some but not all prescriptions / treatments  
  6 [ ]

2. **For the certificates of incapacity that** are in the case-notes, copy below what is written on each one of them (what they cover), regarding

a. **“in relation to a decision about the following medical treatment”** ..........................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
   ..............................................................................................................................................................................
Identification number [ ] [ ] [ ] [ ]

“medical treatment to be authorised by this certificate until (date)” .................................................................
“date the certificate was signed” .................................................................................................................................

b. “in relation to a decision about the following medical treatment” .................................................................
........................................................................................................................................................................................
........................................................................................................................................................................................
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........................................................................................................................................................................................
........................................................................................................................................................................................

“medical treatment to be authorised by this certificate until (date)” .................................................................
“date the certificate was signed” .................................................................................................................................

c. “in relation to a decision about the following medical treatment”
........................................................................................................................................................................................
........................................................................................................................................................................................
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........................................................................................................................................................................................
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“medical treatment to be authorised by this certificate until (date)” .................................................................
“date the certificate was signed” .................................................................................................................................

H. ANY OTHER IMPORTANT POINTS?
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PART II

HEALTH CHECK

(THE A - Z OF HEALTH)
A. ABOUT THE HEALTH CHECK

Date of the health check (date / month / year) 

Review completed by (provide name, and tick grade)

- LD nurse I
- LD nurse H
- LD nurse G
- Primary Care nurse G
- LD nurse E
- Doctor
- Other & specify

Before we start checking your health, I’d like to ask a few background questions about your supports

Person supporting the client (provide name, and tick relationship)

- Next of kin
- Other relative
- Principle paid support contact
- Other paid support worker
- Other & specify

How long has the supporting person known the client (in years and months)?

B. PERSONAL DETAILS

1. Home telephone number

2. First language

3. Gender (Please tick)
   - Male
   - Female
4. **Marital status** *(Please tick)*

- Married / live in partner: 1
- Separated / divorced: 2
- Single: 3
- Widow/er: 4

5. **Ethnicity** *(Please tick)*

- Indian: 1
- Pakistani: 2
- Bangladeshi: 3
- Chinese: 4
- Caucasian: 5
- Black Caribbean: 6
- Black African: 7
- Black other: 8
- Other Asian background: 9
- Mixed background: 10
- Other & specify: 

6. Check **name of GP**

---

**C. SOCIAL SUPPORTS**

1. **Accommodation** *(Please tick)*

- Parents home: 1
- Other family carers home: 2
- Lives independently +/- children, without any paid support: 3
- Lives independently with spouse / partner +/- children, without any paid support: 4
- Supported group living (shared tenancy, with paid support): 5
- Supported living – individual (single tenancy, with paid support): 6
- Residential care (registered home): 7
- Nursing home: 8
- NHS accommodation: 9
- Other & specify: 

---

Identification number: [ ] [ ] [ ] [ ]
2. Is the accommodation **rented**, or are you (the person with learning disabilities, or the family home *if the person lives there*) paying a mortgage?

   - Accommodation is owned outright
   - [ ]
   - Accommodation is owned with a mortgage
   - [ ]
   - Accommodation is privately rented
   - [ ]
   - Accommodation is rented from a housing association
   - [ ]
   - Other & specify………………………………………………………………………………………….

3. If accommodation type = 5 - 7, specify **level of support** at accommodation. *(Please tick)*

   - Part-times support (less than daily)
   - [ ]
   - Part-times support (daily)
   - [ ]
   - 24 hour support, sleep-in nights
   - [ ]
   - 24 hour support, including wake at night
   - [ ]
   - **Organisation** providing support package………………………………………………………….

4. If accommodation type = 5 – 9, specify **how many paid carers** routinely provide the package *(i.e. the actual number of workers, not the full time equivalent).*

   [ ] [ ]

5. Are the person’s **accommodation needs being met**? *(Please tick & specify if not)*

   - No
   - [ ]
   - Partially
   - [ ]
   - Yes
   - [ ]

6. Does the person have a **car or van** for her / his private use *(i.e. access to a family car when ever needed / wanted; the person does not have to be a driver)*

   - No
   - [ ]
   - Yes
   - [ ]

7. Does the person have **short breaks (respite)** from home? *(Please tick)*

   - None
   - [ ]
   - Holidays with family and / or friends
   - [ ]
   - Respite care unit & specify name……………………………………………………………………...
   - [ ]
   - Short breaks with paid support
   - [ ]
8. Are the person’s **respite care needs being met?** *(Please tick & specify if not)*

<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially</td>
<td>2</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
</tr>
</tbody>
</table>

9. What **employment type/s** does the person have? *(Please tick as many as required)*

<table>
<thead>
<tr>
<th>None</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part time paid employment (30 hours / week or less)</td>
<td>1</td>
</tr>
<tr>
<td>Full time paid employment (more than 30 hours / week)</td>
<td>2</td>
</tr>
<tr>
<td>Paid employment with paid support / employment training</td>
<td>3</td>
</tr>
<tr>
<td>Employed, but only paid up to the subscribed limit</td>
<td>4</td>
</tr>
<tr>
<td>Voluntary work</td>
<td>5</td>
</tr>
<tr>
<td>College</td>
<td>6</td>
</tr>
<tr>
<td>Day centre &amp; specify name</td>
<td>7</td>
</tr>
<tr>
<td>Extra 1:1 support to access a day centre &amp; specify centre</td>
<td>8</td>
</tr>
<tr>
<td>1:1 paid support for day opportunity (as part of 24 hour support package)</td>
<td>9</td>
</tr>
<tr>
<td>1:1 paid support for day opportunity (separate from support package at home)</td>
<td>10</td>
</tr>
<tr>
<td>Looking after home and family</td>
<td>11</td>
</tr>
<tr>
<td>Retired from paid work</td>
<td>12</td>
</tr>
<tr>
<td>School</td>
<td>13</td>
</tr>
<tr>
<td>Other &amp; specify</td>
<td></td>
</tr>
</tbody>
</table>

10. Are the person’s **employment needs being met?** *(Please tick & specify if not)*

<table>
<thead>
<tr>
<th>No</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially</td>
<td>2</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
</tr>
</tbody>
</table>

Identification number [    ] [    ] [    ] [    ]
11. **Next of kin forename**…………………………………………………………………………………
    
    Next of kin **surname**………………………………………………………………………………
    
    Next of kin address1 (flat number, **house number, street, district**) …………………
    
    Next of kin address2 (**town, city**) ……………………………………………………………
    
    Next of kin address3 (**post code**) ……………………………………………………………
    
    Next of kin **telephone number**……………………………………………………………………

    Next of kin’s **relationship** to client? *(Please tick)*
    
    Parent 1 [ ]
    Sibling 2 [ ]
    Other relative 3 [ ]
    Other & specify………………….……...4 [ ]

    Is next of kin the person’s **main carer** / support? *(Please tick)*
    
    No 0 [ ]
    Yes 1 [ ]

    If YES, what is the relative’s date of birth? [ ] [ ] / [ ] [ ] / [ ] [ ]

12. If next of kin is not the person’s main carer / support then record **principle contact** details:

    Principle contact **forename**……………………………………………………………………
    
    Principle contact **surname**……………………………………………………………………
    
    Principle contact address1 (flat number, **house number, street, district**) …………………
    
    Principle contact address2 (**town, city**) …………………………………………………
    
    Principle contact address3 (**post code**) …………………………………………………
    
    Principle contact **telephone number**…………………………………………………………

    If principle contact is a paid worker, name of employing organisation…………………………

13. Does the person have a **welfare guardian**? If YES:

    Welfare guardian **name**……………………………………………………………………
    
    Welfare guardian address1 (flat number, **house number, street, district**).………………
    
    Welfare guardian address2 (**town, city**)………………………………………………
    
    Welfare guardian address3 (**post code**)………………………………………………

    Welfare guardian **telephone number**…………………………………………………………

    If YES, Does the welfare guardian have powers under Part V (medical treatment and research) of the Adults with Incapacity (Scotland) Act?
    
    No 0 [ ]
    Yes 1 [ ]
Does the person need a welfare guardianship arranging? .................................................................

14. Does the person have someone whom she / he is particularly close to: a **special relationship** with a relative, partner or a best friend. Would that person regard the relationship as very close? (*Do not include the expected level of interest and concern that a responsible support worker would have for a client*)

   - No 0 [ ]
   - Yes 1 [ ]
   - Yes, several 2 [ ]

15. Over the **last 7 days**, how many people has the person had a **confrontation** with, or an angry exchange? (Include descriptions of bullying, harassment, abuse or aggression) [ ] [ ] [ ]

16. Over the **last 7 days**, how many people has the person had a **minor disagreement** or problem with? [ ] [ ] [ ]

17. Over the **last 7 days**, how many people has the person had an **enjoyable social interaction** with? [ ] [ ] [ ]

18. May I ask what **income** the person has, e.g. benefits?

   - Benefits only 1 [ ]
   - Pension 2 [ ]
   - Paid employment 3 [ ]
   - Other & specify ............................................................ [ ]
   - Not known [ ]

19. Does the person need any **advice on benefits**?

   - No 0 [ ]
   - Yes 1 [ ]

   *Refer for advice if needed*

20. May I ask about your household’s **income**? This card shows income from all types of sources, before any deductions for tax, national insurance etc. Just tell me the number besides the row that applies to you. *(For persons living with a shared tenancy, residential care, nursing care, or NHS accommodation, just include their own income. Give the person the showcard)* [ ] [ ] [ ]
D. PROFESSIONAL SUPPORTS

1. Which of these **professionals** is the person in contact with?

<table>
<thead>
<tr>
<th>Professional</th>
<th>Tick if in contact</th>
<th>Tick if they are the care manager</th>
<th>Name of professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD nurse</td>
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<tr>
<td>Social worker</td>
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<tr>
<td>Occupational therapist</td>
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<tr>
<td>Physiotherapist</td>
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<tr>
<td>Dietician</td>
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<td>Podiatrist</td>
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<td>Psychologist</td>
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<tr>
<td>Psychiatrist</td>
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<tr>
<td>S&amp;LT</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy nurse</td>
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<tr>
<td>Practice nurse</td>
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</tbody>
</table>

2. Any **other doctors or other health professionals** that the person sees, and where:

<table>
<thead>
<tr>
<th>Professional type</th>
<th>Name of professional</th>
<th>Place of contact</th>
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<tbody>
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</table>
E. OVERVIEW OF HEALTH PROBLEMS AND DRUGS

1. How is the person’s health in general? Would you say it was very good, good, fair, bad, or very bad?
   - Very good 1
   - Good 2
   - Fair 3
   - Bad 4
   - Very bad 5

2. Do you have any long-standing illness, disability, or infirmity? By long standing I mean anything that has troubled you over a period of time, or that is likely to affect you over a period of time. (Do not include learning disabilities)
   - No 2
   - Yes 1

3. What health problems is the person known to have, or receives treatment for. Also ask when each problem was last reviewed by a doctor or other designated health professional. Record here the person’s own interpretation. Does it tally with the information in Part I? If not, try to clarify.

<table>
<thead>
<tr>
<th>Health problem or diagnosis</th>
<th>Age at onset</th>
<th>Estimated date of last review</th>
<th>Does this limit your activities in any way?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>No [ ] 2 Yes [ ] 1</td>
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<td>No [ ] 2 Yes [ ] 1</td>
</tr>
<tr>
<td>Health problem or diagnosis</td>
<td>Age at onset</td>
<td>Estimated date of last review</td>
<td>Does this limit your activities in any way?</td>
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<td>No [ ] 2 Yes [ ] 1</td>
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</table>

4. In the last 2 weeks ending yesterday, did the person have to **cut down on any of the things** she/he usually does during the day or evening because of one of these health problems, injury, or illness?

   No  [ ] 2

   Yes [ ] 1

   If **YES**, for how many days?

5. Is the person with learning disabilities or the person supporting her / him aware of, or **concerned about any health problems** in particular, or any new **symptoms**.

   …………………………………………………………………………………………………………….

   …………………………………………………………………………………………………………….

   …………………………………………………………………………………………………………….

   …………………………………………………………………………………………………………….
6. Does the person have any **problems taking their medications** e.g. problems swallowing tablets, timing of doses, difficulty remembering to take doses, not wanting to take their medications?

……………………………………………………………………………………………………………
……………………………………………………………………………………………………………
……………………………………………………………………………………………………………

7. Ask to see all the **medications** the person is currently taking, and list them. Ask why the person is prescribed each medication, and how long she / he has taken it. Include non-prescription medications such as those bought over the counter e.g. antihistamines, and complementary medications. **Does this list tally with that in Part I, page 10? If not, double check with the person which is accurate and record accurately below.**

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Dose and frequency</th>
<th>Form (e.g. tablets, liquid)</th>
<th>Estimated start date</th>
<th>Reason for prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>9</td>
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<tr>
<td>10</td>
<td></td>
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</tr>
</tbody>
</table>
8. Does the person take vitamins, fish oils, iron supplements, calcium, other minerals, or other supplements?
   - No 2 [ ]
   - Yes 1 [ ]
   - If Yes, please specify……………………………………………………………………………………………………………………….

9. If the person uses inhalers, check their technique. (Please tick)
   - Doesn’t use inhalers 0 [ ]
   - Poor technique 1 [ ]
   - Satisfactory technique 2 [ ]

10. Nurse to record if the person is taking an above BNF dose of antipsychotic drugs. (Please tick)
    (Remember, doses are cumulative if more than one antipsychotic drug is taken.)
    - No 0 [ ]
    - Yes 1 [ ]
    - Not sure [ ]

11. List any allergies that the person has.
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..

12. Does the person get hayfever?
    - No 0 [ ]
    - Yes 1 [ ]

13. Does the person have any problems or symptoms that they or their carer are concerned may be possible drug side effects? (There is an optional checklist at appendix 1.)
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
    ……………………………………………………………………………………………………………..
14. Does the person / carer **know if the G.P. has assessed capacity** and / or issued any certificates under the **Adults with Incapacity (Scotland) Act**?

- No, G.P. has not done this  
  - 0 [ ]
- Yes, G.P. has assessed and / or issued certificate  
  - 1 [ ]
- No, because the person does not have any treatment  
  - 6 [ ]
- They are not sure  
  - 8 [ ]
- Not relevant, as the person clearly has capacity to decide about all their treatments  
  - 9 [ ]

15. **Nurse’s opinion** – does the person have any drugs / treatments that she / he does not have decision-making **capacity to consent** to taking, but for which there was not a certificate in the GP notes as per the **Adults with Incapacity (Scotland) Act**? (Check with Part 1, pages 18 – 19.)

- Yes, **Please specify**………………………………………………………………………………..  
  - 1 [ ]
- No  
  - 2 [ ]
- Partly, **Please specify**………………………………………………………………………………..  
  - 3 [ ]

**Assessment of capacity should cover the following areas:**

- Does the person know the reason for the treatment and potential benefits?
- Does the person understand the potential consequences and risks if they did not have it?
- Does the person understand the possible side effects and risks the treatment may cause?
- Does the person understand what alternative options are available to them, and their possible benefits and risks?
- Can the person retain and communicate this information and their decision?

**F. MENTAL HEALTH**

1. Does the person have any **mental health needs**, emotional problems, or psychological problems, dementia or other psychiatric ill-health?

- No  
  - 0 [ ]
- Yes  
  - 1 [ ]
- Not sure  
  - [ ]

If **YES**, specify type of problem and any support the person receives……………………………………

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………
2. Administer the **PAS-ADD Checklist**. (The Checklist asks about things that can happen sometimes if a person has mental health problems. It helps to decide whether a fuller assessment of an individual’s mental health may be useful. Remember that for some types of enduring mental ill-health symptoms can be present for very long periods of time – they should be ticked as present, even if a prior period free from them may no longer be identifiable. Do not, however, tick life-long traits. After completing the Checklist, ask the additional questions below)

3. Ask these questions in addition to the **PAS-ADD Checklist** questions. Each question asks about problems the person may have had **IN THE PAST FOUR WEEKS**. Read out each symptom and put a tick in the column which gives the best answer to the question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Has not happened or has always been like this</th>
<th>Has occurred</th>
<th>Present in a severe form for much of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased lability of mood; mood rapidly alternating between misery and elation, or between misery and normal mood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of usual social inhibitions, indiscretion, or inappropriate social behaviour e.g. talking to strangers, overfamiliarity which is out of keeping with usual behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased interest in sex, or sexual indiscretions which are out of keeping with usual behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of energy, has become tired much of the time (if known to be due to exertion or physical illness, tick the first column)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive talking, singing, or laughing, <strong>more</strong> so than usual for the person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>More</strong> tearful than usual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less able to understand instructions or conversation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change <strong>in</strong> the person’s use of language, such as communicating less, or speech being more muddled up than usual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks about ending life, or life not being worth living, or hopeless about the future, or has tried to take her/his own life</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you cannot answer a question, then PUT A LINE THROUGH THE QUESTION and write the reason. For example, if the person does not speak well enough for you to know if they have strange beliefs, cross out that question and write that reason.

<table>
<thead>
<tr>
<th>Identification number [   ][   ][   ][   ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not happened or has always been like this</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
</tbody>
</table>

10. Strange experiences, such as hearing noises or voices that other people can’t hear, or seeing things that are not there

11. New or strange ideas/beliefs/thoughts which do not make sense to other people, or which cannot be true

12. Thinking that people or the television are referring to her/him, or giving her/him messages or instructions (when this is not actually happening)

How many ticks are there on the **PAS-ADD Checklist**? (Exclude ticks in the yellow column)[   ][   ]

How many symptoms are present on the **PAS-ADD Checklist** (Exclude ticks in the yellow column) + the additional questions above (Exclude ticks in the grey column) (i.e. add the two up together)? [   ][   ]

4. Does the person already see a learning disabilities psychiatrist?
   - Yes & specify whom……………………………………………………………………………………… 1 [   ]
   - No………………………………………………………………………………………………………….. 2 [   ]
   - Not sure…………………………………………………………………………………………………… 2 [   ]

5. If the person has a combined score of **2 or more**, or has a positive score for any of the “special risk” questions (questions 9-12 above, or the first two questions on the **PAS-ADD Checklist**), you should refer to the C.E.D.D. Clinical Service for psychiatric assessment. If you decide not to refer, why not?
   - Symptoms are explained by physical illness…………………………………………………………………………………………………… 1 [   ]
   - Person already sees a psychiatrist…………………………………………………………………………………………………… 2 [   ]
   - Person declines referral……………………………………………………………………………………………………………………… 3 [   ]
   - Carer declines referral on person’s behalf………………………………………………………………………………………………… 4 [   ]
   - Other & specify………………………………………………………………………………………………………………………………………… 1 [   ]
6. Does the person have a pervasive developmental disorder, autism, Asperger’s syndrome, or autistic spectrum disorder?

No 0 [ ]
Yes 1 [ ]
Not sure [ ]

If YES, specify type of problem and any support the person receives………………………………
………………………………………………………………………………………………………………
………………………………………………………………………………………………………………

N.B. Indicators of autistic spectrum disorder include long-standing problems out of keeping with the person’s overall level of ability in all the areas of:

- Impaired reciprocal social interaction (e.g. limited eye to eye gaze; limited feelings for others; difficulty making relationships or lack of interest in relationships)
- Impaired receptive or expressive language as used in social communication (includes abnormal use of language)
- Lack of empathy (e.g. abnormal responses to other people’s emotions; unable to see things from other person’s point-of-view; lack of imaginative play / let’s pretend)
- Restrictive, repetitive and stereotyped patterns of behaviour, interests and activities (e.g. unusual attachments to objects; touches, smells, tastes things inappropriately; repetitive behaviours such as hand flapping, spinning, tiptoe walking; rituals; unable to cope with change in routine)

7. Nurse’s opinion: Do you think the person might have an autistic spectrum disorder, even though this has not been previously diagnosed? (There is an optional checklist at appendix 2.)

No 0 [ ]
Yes 1 [ ]
Not sure [ ]

If you think the person may have an autistic spectrum disorder, you should refer to the C.E.D.D. Clinical Service for a psychiatric diagnostic assessment. If you decide not to refer, why not?

Symptoms are explained by physical illness 1 [ ]
Person already sees a psychiatrist 2 [ ]
Person declines referral 3 [ ]
Carer declines referral on person’s behalf 4 [ ]
Other & specify………………………………………………………………………………………….. [ ]
8. Does the person have any **problem behaviours**, challenging behaviour, or special needs related to behaviour?
   
   No 0 [ ]
   Yes 1 [ ]
   
   If **YES**, specify type of problem and any support the person receives……………………………………
   …………………………………………………………………………………………………………………

9. Some people need extra support because they have problems with their behaviour. I’d like to ask you some routine questions about **specific types of problem behaviours**.

   **Note:** Throughout this section, ask the first question to ascertain if the problem behaviour occurs.

   If this type of problem behaviour does **not** occur, skip to the next type of problem behaviour, and ask the first question to ascertain if that type of problem behaviour occurs.

   If the first question suggests that the problem behaviour does occur, work through the additional questions in that section, to ascertain:

   A. the frequency, duration, and severity of the problem behaviour,
   B. whether the problem behaviour only occurs when the person has physical ill-health or mental ill-health,
   C. the extent to which it has a negative impact on the person’s quality of life, or the quality of life of other people, and
   D. whether it occurs only in one very specific situation which is understandable (i.e. other people in the same situation would be expected to behave in a similar way).

   Then use this information to make a clinical judgement as to whether you think the person actually has this type of problem behaviour, and if so whether it occurs only when the person is ill, or occurs at other times. Then move onto the next type of problem behaviour.

   Some problem behaviours can be prevented through the vigilance of paid or family carers. For example, a person with pica may be prevented from eating non-nutrients through close supervision and activities, or a person may be prevented from committing offences through 24 hour supervision. In these cases, where your clinical judgement is that the problem behaviour would occur were it not for the successful supervision that necessarily must continue, please rate the person as “**yes**”, she / he does have that type of problem behaviour.
VERBAL AGGRESSION Does the person have any problem with verbal aggression? E.g. shouting, screaming, swearing? Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur?

B. If YES, how long does it last when it occurs?

C. If YES, how severe is it?

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings)

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have verbally aggressive behaviour?

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<tr>
<td>No</td>
<td>0</td>
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<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Yes, but only when ill (physical or mental ill-health)</td>
<td>2</td>
</tr>
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</table>
PHYSICAL AGGRESSION Does the person have any problem with physical aggression? E.g. scratching, pinching, nipping, pulling hair, hitting, kicking, punching? Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur?........................................................................................................

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A. If YES, how long does it last when it occurs? ..........................................................................................

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A. If YES, how severe is it?..........................................................................................................................

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B. If YES, does it only occur when the person has a physical illness?..........................................................

B. If YES, does it only occur when the person has some other psychiatric illness?..................................

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social
opportunities, community integration, access to services, or restriction of choices, or skills, or use of
skills..........................................................................................................................................................

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C. If YES, does it impact on another person’s quality of life.................................................................

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C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or
safety?.........................................................................................................................................................

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be
more severe or distressing in certain identified settings)........................................................................

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The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both,
C shows it is has negative consequences for the person or others, and D shows potentially it can
happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have physically aggressive behaviour?

No 0 [ ]
Yes 1 [ ]
Yes, but only when ill (physical or mental ill-health) 2 [ ]
DESTRUCTIVENESS TO PROPERTY Does the person have any problem with destructive behaviour? E.g. throwing things, smashing things, ripping or shredding things, pulling things down, punching or kicking things?

Yes [ ]   No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur? ........................................................................................................................................
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A. If YES, how long does it last when it occurs?
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A. If YES, how severe is it?
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B. If YES, does it only occur when the person has a physical illness?
B. If YES, does it only occur when the person has some other psychiatric illness?

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills

C. If YES, does it impact on another person’s quality of life.

C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety?

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings)

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have destructive behaviour?

No [ ]

Yes [ ]

Yes, but only when ill (physical or mental ill-health) [ ]
SELF INJURY Does the person have any problem with self injury? E.g. scratching or pinching self, skin-picking, picking at wounds, pulling hair out, head banging, head or body punching, hitting or slapping, throwing self on floor, pulling out nails? Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following):

A. If YES, how often does it occur? .................................................................

B. If YES, how long does it last when it occurs? .................................................................

C. If YES, how severe is it? ...........................................................................................

B. If YES, does it only occur when the person has a physical illness? .................................................................

B. If YES, does it only occur when the person has some other psychiatric illness? .................................................................

C. If YES, does it have a negative impact on the person’s life? E.g. personal injury, restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills .................................................................................................

C. If YES, does it impact on another person’s quality of life .................................................................

C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety? .................................................................................................

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings) .................................................................................................

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have self-injurious behaviour?

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<th>Oppinon</th>
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<tr>
<td>No</td>
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<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Yes, but only when ill (physical or mental ill-health)</td>
<td>2</td>
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</table>
SEXUALLY INAPPROPRIATE BEHAVIOUR Does the person have any sexual problems or committed any sexual offences? E.g. Does she / he not know not to masturbate in public or strip or expose her / himself in public?

Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur? .................................................................  

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A. If YES, how long does it last when it occurs? ....................................................  

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A. If YES, how severe is it? ..................................................................................  

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B. If YES, does it only occur when the person has a physical illness?  

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B. If YES, does it only occur when the person has some other psychiatric illness?  

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C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills  

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C. If YES, does it impact on another person’s quality of life  

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C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety?  

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D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings)  

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The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have sexually inappropriate behaviour?

No [ ]

Yes [ ]

Yes, but only when ill (physical or mental ill-health) [ ]
Identification number [ ] [ ] [ ] [ ]

OPPOSITIONAL BEHAVIOUR Does the person have any problem with oppositional behaviour?
E.g. deliberately not following requests, disagreeing with any community or household rules or regulations, not accepting responsibilities?

Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur? ......................................................................................................
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A. If YES, how long does it last when it occurs? ......................................................................................................
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A. If YES, how severe is it? ...................................................................................................................
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B. If YES, does it only occur when the person has a physical illness? ....................................................
B. If YES, does it only occur when the person has some other psychiatric illness? ..........................
C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills.................................................................
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C. If YES, does it impact on another person’s quality of life ..............................................................
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C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety? ..................................................................................................................................................
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D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings) ..................................................................................................................................................
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The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have oppositional behaviour?

No 0 [ ]
Yes 1 [ ]
Yes, but only when ill (physical or mental ill-health) 2 [ ]
EXCESSIVELY DEMANDING Does the person have any problem with excessively demanding behaviour? E.g. requiring continuous attention, much more so than the average person, unable to amuse self? Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur? ........................................................................................................
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A. If YES, how long does it last when it occurs? .............................................................................
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A. If YES, how severe is it? ...................................................................................................................
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B. If YES, does it only occur when the person has a physical illness? ..........................................
B. If YES, does it only occur when the person has some other psychiatric illness? .....................

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social
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C. If YES, does it impact on another person’s quality of life............................................................
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C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or
safety? ..............................................................................................................................................
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D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may
be more severe or distressing in certain identified settings) ..........................................................
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The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both,
C shows it is has negative consequences for the person or others, and D shows potentially it can
happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have excessively demanding behaviour?

No 0 [ ]
Yes 1 [ ]
Yes, but only when ill (physical or mental ill-health) 2 [ ]
WANDERING Does the person have any problem with wandering? E.g. walking off or going missing?

Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur?..........................................................................................................................

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A. If YES, how long does it last when it occurs?

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A. If YES, how severe is it?.................................................................................................................................

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B. If YES, does it only occur when the person has a physical illness?

B. If YES, does it only occur when the person has some other psychiatric illness?

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills......................................................................................................................................................

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C. If YES, does it impact on another person’s quality of life

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C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety?

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings).

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have wandering behaviour?

No 0 [ ]

Yes 1 [ ]

Yes, but only when ill (physical or mental ill-health) 2 [ ]
FAECAL SMEARING Does the person have any problem with soiling or smearing or playing with faeces?

Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur?……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………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………………………………………………
**Identification number** [ ] [ ] [ ] [ ]

**PICA** Does the person have any problem with **pica** - eating things that are not usually considered to be food? E.g. dirt or soil, frozen food that hasn’t been defrosted, cigarette butts, coffee grounds, or clothes, or materials?  

Yes [ ] No [ ]

(If NO, move onto the next specific type of problem behaviour. If YES, answer the following:)

A. If YES, how often does it occur? .................................................................

A. If YES, how long does it last when it occurs? .............................................

A. If YES, how severe is it? ..............................................................................

B. If YES, does it only occur when the person has a physical illness? .............

B. If YES, does it only occur when the person has some other psychiatric illness? ....

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills .................................................................

C. If YES, does it impact on another person’s quality of life ............................

C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety? ............................................................................

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings) ...........................................

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

**Nurse’s opinion – does the person have pica?**

No 0 [ ]

Yes 1 [ ]

Yes, but only when ill (physical or mental ill-health) 2 [ ]
OTHER PROBLEM BEHAVIOUR Does the person have any other problem behaviours?

(If NO, move onto the next section. If YES, answer the following:)

A. If YES, how often does it occur?

A. If YES, how long does it last when it occurs?

A. If YES, how severe is it?

B. If YES, does it only occur when the person has a physical illness?

B. If YES, does it only occur when the person has some other psychiatric illness?

C. If YES, does it have a negative impact on the person’s life? E.g. restriction of lifestyle, social opportunities, community integration, access to services, or restriction of choices, or skills, or use of skills.

C. If YES, does it impact on another person’s quality of life.

C. If YES, does it put at risk the person’s health and / or safety, or another person’s health or safety?

D. If YES, where does it occur? (i.e. occurs in a range of personal and social settings, although may be more severe or distressing in certain identified settings)

The problem behaviour is significant if it occurs, and criteria A shows it is frequent or severe or both, C shows it is has negative consequences for the person or others, and D shows potentially it can happen in more than just one situation where others might behave in a similar way.

Nurse’s opinion – does the person have any other problem behaviour?

No 0 [ ]

Yes 1 [ ]

Yes, but only when ill (physical or mental ill-health) 2 [ ]
Throughout Sections G - Z, except where indicated otherwise, put a tick, cross, ?, or NA in the [ ]:

No = X
Yes = √
Unsure = ?
Not applicable = NA

Where there are a choice of [ ]s to fill in for an item, you need only tick one of the [ ]

Do not leave any other of the [ ]s empty, unless the person declines to answer the question

>>>>>> Provide further information on symptoms / anomalies >>>>>>
(Including an indication of severity and / or frequency)

>>>>>> These questions refer to the person’s health over the LAST 12 MONTHS >>>>>>
G. BREATHING

1. Does the person have a known breathing problem e.g. asthma, chronic bronchitis, repeated chest infections? [ ]
   If YES, specify………………………………………………………………………………………………………
   ……………………………………………………………………………………………………………………………

2. Does the person have a cough? [ ]

3. Does the person cough up blood? [ ]

4. Does the person usually cough up phlegm / mucous / sputum from the chest e.g. first thing in the morning in winter, or during the day or at night? [ ]
   If YES, is this for as much as most days for at least 3 months of the year? [ ]

5. Does the person get short of breath when hurrying on level ground, or walking up a slight hill? (Please tick one box)
   No 2[ ]
   Yes 1[ ]
   Never hurries or walks up hills 3[ ]
   Cannot walk 4[ ]
   If YES, does the person get short of breath when walking with people of similar age on level ground? (Please tick)
   No 2[ ]
   Yes 1[ ]
   Never walks with people of own age on level ground 3[ ]
   If YES, does the person have to stop for breath when walking at own pace on level ground?
   Yes 1[ ]
   No 2[ ]
6. Does the person **wheeze**, or have they had a **whistle in their chest** at any time in last 12 months?

   If YES, has the person been **short of breath** with wheezing? (Please tick)
   
   Yes
   No

   If YES, is the person’s breathing normal **between these episodes**? (Please tick)
   
   Yes
   No

   If YES, how many episodes of wheezing / whistling have you had in the last 12 months? (Please tick)
   
   1 – 3
   4 – 12
   more than 12

   If YES, Has the person been **woken at night** by an episode of shortness of breath in the last 12 months? (Please tick)
   
   Never woken with wheezing
   Woken less than 1 night / week
   Woken 1 night / week or more

   If YES, has it been severe enough to **limit the person’s speech** to only 1 or 2 words between breaths? (Please tick)
   
   Yes
   No
   Person does not have verbal speech

   If YES, how much did the wheezing / whistling **interfere with** the persons normal **daily activities** over the last 12 months? (Please tick)
   
   Not a lot
   A little
   Quite a lot
   A lot

7. Further information

   ……………………………………………………………………………………………………………………………………………………………………………………………………………………

   …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………
H. COMMUNICATION

1. Is the person able to use **words**?
   - No, can’t use words \( 0 \) \[ \]
   - Yes, can use words \( 1 \) \[ \]

2. Should other people use **objects / gestures / pictures** as a recognised way of communicating with the person if she / he does not use words?
   - IF YES, is a SALT referral needed for training?
     - No \( [ ] \)
     - Yes \( [ ] \)

3. Does the person use a **high-tech communication aid** e.g. a switch / computer-based aid? \( [ ] \)

4. Has the person had a significant change in their **communication ability**? \( [ ] \)

5. Has the person ever requested or wanted to see a S&LT (self-referral)? \( [ ] \)

6. Further information ………………………………………………………………………………………………………..
   …………………………………………………………………………………………………………………………………..

I. STOMACH, BOWEL AND NUTRITION

1. Does the person have a known **stomach, bowel or nutritional problem** e.g. peptic ulcer, swallowing problem, reflux disorder, underweight?
   - If YES, specify…………………………………………………………………………………………………………
     ……………………………………………………………………………………………………………………………..

2. Does the person have **aspiration problems / repeated chest infection / cough** or **dyspnoea or cyanosis after eating**, suggestive of aspiration? \( [ ] \)

3. Has the person **lost weight without trying to**? \( [ ] \)

4. Does the person have **trouble swallowing / choking / spluttering**? \( [ ] \)
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<tr>
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<th>Identification number</th>
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<tbody>
<tr>
<td>5.</td>
<td>Does the person <strong>regurgitate</strong> / <strong>vomit</strong>?</td>
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<td>6.</td>
<td>Does the person get &quot;<strong>heart burn</strong>&quot; or indigestion?</td>
<td>[ ]</td>
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<td>7.</td>
<td>Does the person have <strong>diarrhoea</strong>?</td>
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<td>8.</td>
<td>Does the person have <strong>black bowel motions</strong>?</td>
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<td>9.</td>
<td>Does the person have <strong>blood</strong> in their stool / <strong>bowel motion</strong>?</td>
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<td>10.</td>
<td>Does the person get <strong>constipated</strong>?</td>
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<td>11.</td>
<td>Does the person have <strong>abdominal</strong> / <strong>stomach pain</strong>?</td>
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<td>12.</td>
<td>Are you concerned about the person's <strong>diet</strong>?</td>
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<td>13.</td>
<td>Does the person have a problem <strong>drinking</strong> enough fluid (&gt; 1,600 ml per day = 8 teacups)?</td>
<td>[ ]</td>
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<td>14.</td>
<td>Does the person have <strong>excessive thirst</strong>?</td>
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<td>15.</td>
<td>Does the person have problems with <strong>tongue thrust, poor lip closure, drooling</strong>?</td>
<td>[ ]</td>
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<td>16.</td>
<td>Does the person require <strong>PEG / tube feeding</strong>?</td>
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<td></td>
<td>If <strong>YES</strong>, specify if there are any <strong>problems</strong> with the parenteral feeding, or with the <strong>stoma</strong></td>
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<td>17.</td>
<td>Does the person require <strong>dietary supplements</strong>?</td>
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<td>18.</td>
<td>Does the person need <strong>assistance with eating</strong> / <strong>drinking</strong> e.g. physical help or equipment?</td>
<td>[ ]</td>
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<td>19.</td>
<td>Does the person seem to experience <strong>discomfort after eating</strong>?</td>
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</tbody>
</table>
20. How **continent** is the person with her / his **bowels**? *(Please tick)*

- Fully continent 1 [ ]
- Occasional accidents / continent with toileting programme 2 [ ]
- Incontinent (wears pads) 4 [ ]

21. Further information........................................................................................................................................................................
........................................................................................................................................................................................................

**J. HEART AND CIRCULATION**

1. Does the person have a known **heart or circulation problem**? [ ]

If **YES**, specify...................................................................................................................................................................................
........................................................................................................................................................................................................

2. Has the person had **any of the following conditions** in the last 12 months, or at any time in the past?

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>In the last 12 months</th>
<th>At any time in the past</th>
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<tr>
<td>Raised blood pressure / hypertension</td>
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<td>[ ]</td>
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<tr>
<td>Angina</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Heart attack / myocardial infarction / coronary thrombosis</td>
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<td>[ ]</td>
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<tr>
<td>Heart murmur</td>
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<tr>
<td>Abnormal heart rhythm / heart racing, beating quickly, or thumping in chest</td>
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<td>[ ]</td>
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<tr>
<td>Heart failure</td>
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<td>[ ]</td>
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<tr>
<td>Stroke / CVA</td>
<td>[ ]</td>
<td>[ ]</td>
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</tbody>
</table>
3. If the person has had raised **blood pressure**, is it still raised now, or **under control**?
   - Still raised 1
   - Under control 2
   - Not known (i.e. needs to have it checked by G.P. / nurse) 3

4. Does the person have **chest pain**, or **discomfort** in the chest?
   - If **YES**, does the person get it when **walking uphill** or hurrying?
     - Yes, on most or all occasions 1
     - No 2
     - Yes, but only sometimes / occasionally 3
     - Never walks uphill or hurries 4
     - Cannot walk 5
   - If **YES**, does the person get it when **walking** at an ordinary pace on the **level**?
     - Yes, on most or all occasions 1
     - No 2
     - Yes, but only sometimes / occasionally 3
     - Never walks at an ordinary pace on the level 4
   - If **YES**, if the person **stands still**, does the **pain go away**? How quickly?
     - Pain goes away in 10 minutes or less 1
     - Pain takes more than 10 minutes to go away 2
     - Pain doesn’t go away 3
   - If **YES**, has it ever been severe across the front of the chest lasting for **half an hour** or more?
     - Yes 1
     - No 2

5. Do the person's **ankles** swell?

6. Has the person in the last 12 months been woken at night by **shortness of breath**?

7. Does the person get **blue skin when it’s not very cold**, e.g. on fingers, lips, toes?

8. Does the person get **pain or discomfort in either legs** which comes on when walking or climbing stairs? *Do not include pain due to arthritis or rheumatism*
K. URINARY SYSTEM

1. Does the person have a known problem with their kidney or bladder e.g. prostate problem, [ ] repeated urine infections?
   If YES, specify…………………………………………………………………………………………

2. Does the person have pain when passing water? [ ]

3. Does the person have blood in the water? [ ]

4. Does the person have hesitancy when trying to pass water, or have to strain? [ ]

5. Does the person have to get up more often in the night to pass water? [ ]

6. Does the person dribble water after completing urination? [ ]

7. Does the person pass water a lot more frequently than usual? [ ]

8. How continent is the person with her / his urine? (Please tick)
   Fully continent 1 [ ]
   Occasional accidents / continent with toileting programme 2 [ ]
   Incontinent at night only 3 [ ]
   Incontinent 4 [ ]

9. Further information…………………………………………………………………………………………

………………………………………………………………………………………………………………
L. MUSCLES, JOINTS AND LOCOMOTION

1. Does the person have a known problem with their muscles, joints or mobility e.g. arthritis, [ ] osteoporosis, scoliosis?
   If YES, specify……………………………………………………………………………………………………….…….
   …………………………………………………………………………………………………………………………….

2. Does the person have joint, back, or muscle pain? [ ]

3. Does the person have any contractures or fixed deformities? [ ]

4. Is the person disabled in all four of their limbs (spastic quadriplegia) and / or does she / he use a molded seat? [ ]

5. Does the person have any problems with their feet, toes or toenails? [ ]

6. Does the person need special footwear or orthoses? [ ]

7. Does the person have a co-ordination problem? [ ]

8. Does the person have a problem with their wheelchair / special seating? [ ]

9. Does the person have any limb injuries / soft tissue injuries? [ ]

10. Has the person a history of broken bones / easily breaking bones? [ ]

11. How mobile is the person? (Please tick)
    Fully mobile 1 [ ]
    Walks with stick/s, frame or some assistance 2 [ ]
    Requires wheelchair when outside only 3 [ ]
    Requires wheelchair in and outside 4 [ ]
    Can weightbear / transfer only 5 [ ]
    Cannot weightbear / transfer 6 [ ]
12. Further information (include details of any mobility aids or requirements for special adaptations) ……………………………………………………………………………………………………………………………………………………

M. SKIN

1. Does the person have a known problem with their skin or nails e.g. eczema, psoriasis? [ ]
   If YES, specify………………………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

2. Does the person have any rashes, or skin infection? [ ]

3. Does the person have dry or itchy skin? [ ]

4. Does the person have any skin breaks / ulcers / pressure sores / bruising [ ]

5. Does the person have a scalp problem? [ ]

6. Further information……………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………
   …………………………………………………………………………………………………………………

N. EPILEPSY

1. Has the person ever experienced seizures, epilepsy or fits? [ ]
   [IF NO, SKIP TO NEXT SECTION O; IF YES, CONTINUE SECTION N]

2. If the person has not had seizures for two or more years, and still takes anti-epileptic drug/s, has their possible discontinuation been attempted? (Please tick)
   No, never suggested 1 [ ]
   No, because person declined 2 [ ]
   No, because carer declined on person’s behalf 3 [ ]
   Previous attempt at discontinuation failed 4 [ ]
   Other & specify……………………………………………………………………………………………… [ ]
3. If the person has a known **epilepsy syndrome**, please specify………………………………………………

4. Which **type/s of seizure/s** does the person experiences *(Please tick as many as required)*

- Not sure / not known [88]
- Complex partial [1]
- Simple partial [2]
- Primary generalised tonic-clonic [3]
- Absence [4]
- Tonic [5]
- Clonic [6]
- Atonic [7]
- Myoclonic [8]
- Atypical [9]
- Secondary generalized tonic-clonic [10]
- Other & specify…………………………………………………………………………………………………………… [ ]

5. If possible, record the **number of seizures per full calendar month**, for the last four months*

<table>
<thead>
<tr>
<th>Month</th>
<th>Type i: frequency</th>
<th>Type ii: frequency</th>
<th>Type iii: frequency</th>
<th>Type iv: frequency</th>
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</table>

*If seizure frequency is unknown, ask for an estimate i.e. the number of seizures in the last week or month or year……………………………………………………………………………………………………………………

6. How often do the person’s seizures occur now, **compared with previously**?

- Less often now [0]
- No change [1]
- More often now & describe………………………………………………………………………………………………………………………… [ ]

7. When was the person’s epilepsy and anti-epileptic **drugs last reviewed**?…………………………

   Is a review outstanding (i.e. not reviewed in the last 12 months)? [ ]
O. NERVOUS SYSTEM (OTHER THAN EPILEPSY)

1. Does the person have a known problem with their nervous system e.g. migraine, head injury? [ ]
   If YES, please specify

2. Does the person have faints? [ ]

3. Is the person more unsteady, clumsy or unco-ordinated than usual? [ ]

4. Does the person have a tremor? [ ]

5. Have the person’s arms or legs become weaker than usual? [ ]

6. Does the person have tingling or strange feelings in the skin? [ ]

7. Does the person experience frequent headaches? [ ]

8. Further information…………………………………………………………………………………………

[FOR MEN, NOW SKIP TO SECTION Q]

P. WOMEN’S HEALTH

1. Does the woman have a need related to women’s health or sexual health e.g. polycystic ovaries, menopausal symptoms? [ ]
   If YES, specify…………………………………………………………………………………………

Identification number [  ] [  ] [  ] [  ]
2. Does the woman have regular menstrual periods? (Please tick)
   - Regular periods: 0
   - Periods have ceased: 1
   - Never menstruated: 2
   - Periods are irregular: 3
   - Other & specify: 

   If NO, enter age at cessation of periods? (Enter 88 if not known)

3. Has the woman ever been pregnant?
   - If YES, information / outcome:

4. Does the woman have any menopausal symptoms (e.g. hot flushes, night sweats)?

5. If the woman’s periods have stopped and she has menopausal symptoms, specify whether she takes HRT? (Please tick)
   - No menopausal symptoms, doesn’t take HRT: 0
   - Hasn’t been offered HRT, because no troublesome symptoms: 1
   - Hasn’t been offered HRT, although symptoms are causing distress: 2
   - Takes HRT: 3
   - Choose not to take HRT: 4
   - Carer declined HRT on her behalf: 5
   - Individual medical contraindications (e.g. FH of breast cancer): 6
   - Tried HRT but it caused problems (e.g. migraine): 7
   - Tried HRT but didn’t like it: 8
   - Previously took HRT, now discontinued: 9
   - Other & specify: 

6. Does the woman have pre-menstrual tension?

7. Does the woman have mid-cycle bleeds?

8. Does the woman have painful periods?

9. Does the woman have very heavy periods?
10. Does the woman have abnormal vaginal discharge or irritation? [ ]

11. What type of contraception does the woman use? (Please tick)
   - Not required 0 [ ]
   - None, although sexually active and pre-menopausal 1 [ ]
   - Pill 2 [ ]
   - Depo-provera 3 [ ]
   - Coil 4 [ ]
   - Sheath 5 [ ]
   - Cap 6 [ ]
   - Rhythm 7 [ ]
   - Other & specify……………………………………………………………………………… [ ]
When was the contraception started? ………………………………………………………………………

12. Is the woman in the age category for smears (20 – 60 years)? [ ]
   If YES, when was her last smear? (Cross-check with information in Part I, page 6) …………
   If YES, is her smear in-date (i.e. aged 20 – 60, and smear done in last 3 years)? (Please tick)
   - Out-of-date 0 [ ]
   - In-date 1 [ ]
   - Not known 9 [ ]

13. If the woman is aged 20 - 60 years, may ever have been sexually active (or sexually abused), and has NOT had a smear in the last 3 years, indicate why not? (Please tick)
   - Not offered 0 [ ]
   - Person distressed by the procedure 1 [ ]
   - Smear planned 2 [ ]
   - Preparation planned 3 [ ]
   - Preparation in progress 4 [ ]
   - Person refused 6 [ ]
   - Carer refused on person’s behalf 7 [ ]
   - Not in the recommended age category requiring a smear 9 [ ]
   - Other & specify……………………………………………………………………………… [ ]

14. Does the woman have a problem regularly checking her own breasts? [ ]
15. Is the woman in the category recommended to have mammography (aged 50 – 70 years or has a close family relative who had / has breast cancer)?

If YES, when was her last mammogram? (Cross-check with Part I, page 6)………………

If YES, is her mammogram in-date (aged 50 – 70 years, or has a close family relative who had / has breast cancer, and mammogram done in last 3 years)? (Please tick)

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<tr>
<td>Out-of-date</td>
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<tr>
<td>In-date</td>
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<tr>
<td>Not known</td>
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16. If the woman is aged 50 – 70 years, or has a close family relative who had / has breast cancer), and has NOT had a mammogram in the last 3 years, indicate why not?

(Please tick)

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<td>Not offered</td>
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<td>Person distressed by procedure</td>
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<td>Mammogram planned</td>
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<td>Preparation planned</td>
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<tr>
<td>Preparation in progress</td>
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<td>Carer refused on person’s behalf</td>
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<tr>
<td>Not in the recommended category requiring a mammogram</td>
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<td>Other &amp; specify…………………...</td>
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17. Further information……………………………………………………………………………………

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[FOR WOMEN, NOW SKIP TO SECTION R]

Q. MEN'S HEALTH

1. Does the man have a need related to men’s health or sexual health e.g. prostate problem? [ ]

If YES, specify…………………………………………………………………………………………

………………………………………………………………………………………………………………
2. Does the man have a **discharge** from his penis? [   ]

3. Does the man have any **sores or scars** on his penis? [   ]

4. Does he have any **swellings, lumps or inflammation** / redness on his testes? [   ]

5. Does he have any **swellings** in his groin? [   ]

6. Does the person have a problem examining his **testes**? [   ]

7. Further information…………………………………………………………………….………………
…………………………………………………………………………………………………..…………
…………………………………………………………………………………………………..…………

R. ABILITY AND DEVELOPMENT

1. Administer the **Vineland Scale (survey form)**. *(Add the scores up after you return to base) (Please tick here to confirm that you have administered the scale)*

   Vineland Scale administered [   ]

   **IF ADMINISTERED, NOW SKIP TO Q8.**

   **IF NOT ADMINISTERED, specify why, and administer the short review of abilities and skills R2 – R7** ........................................................................................................................................

2. How much support does the person need with **eating and drinking**? *(Please tick)*

   - Totally independent 1 [   ]
   - Minimum assistance 2 [   ]
   - Regular prompting / supervision 3 [   ]
   - 1:1 support required 4 [   ]
   - 1:1 support required and special equipment / positioning or PED feeding 5 [   ]
3. How much support does the person need with **intimate care** e.g. bathing, dressing? *(Please tick)*
   - Fully independent 1 [ ]
   - Minimum assistance 2 [ ]
   - Regular prompting / supervision 3 [ ]
   - 1:1 support required, but able to contribute in a limited way - may require special lifting equipment 4 [ ]
   - 1:1 support required, unable to contribute and totally dependent – requires special lifting equipment 5 [ ]

4. How much support does the person need with **personal safety**? *(Please tick)*
   - Aware of personal safety and acts accordingly 1 [ ]
   - Minimum assistance 2 [ ]
   - Some awareness / appropriate action, but requires some supervision 3 [ ]
   - Requires constant supervision to ensure safety 4 [ ]
   - Total dependency for personal safety 5 [ ]

5. How much support does the person require with **communication**? *(Please tick)*
   - Communicates clearly and independently 1 [ ]
   - Communicates reasonably clearly, including using signs / aids 2 [ ]
   - Requires staff support with communication 3 [ ]
   - Much time is required to understand and facilitate the person’s communication 4 [ ]
   - Communication skills are extremely limited 5 [ ]

6. How much support does the person require with **decision making**? *(Please tick)*
   - Makes own decisions in an informed way 1 [ ]
   - Minimum support to make own decisions 2 [ ]
   - Can make some choices / decisions 3 [ ]
   - Support required for even simple decisions 4 [ ]
   - Total dependence on others for decision making / choices 5 [ ]

7. **Add up** the sum of scores in R2 – R6 [ ] [ ] [ ]
8. Nurse’s opinion: estimation of the person’s ability level (Please tick)
   - Mild learning disabilities (I.Q. = 50 – 69; mental ability = 9 - 12 years) 1 [ ]
   - Moderate learning disabilities (I.Q. = 35 – 49; mental ability = 6 - 9 years) 2 [ ]
   - Severe learning disabilities (I.Q. = 20 – 34; mental ability = 3 - 6 years) 3 [ ]
   - Profound learning disabilities (I.Q. < 20; mental ability = 0 -3 years) 4 [ ]
   - Unsure
   - Person does not have learning disabilities 9 [ ]

9. What is the cause of the person’s learning disabilities? (Cross-check with information from Part I, page 9) (Please tick)
   - Unknown, despite investigation 1 [ ]
   - Unknown, and never fully investigated 88 [ ][ ]
   - Down’s syndrome 2 [ ]
   - Tuberous sclerosis 3 [ ]
   - Eclampsia / ante-partum haemorrhage / complications of pregnancy 4 [ ]
   - “Birth injury” 5 [ ]
   - Meningitis/encephalitis 6 [ ]
   - Fragile X syndrome 7 [ ]
   - Head injury 8 [ ]
   - Brain tumour 9 [ ]
   - Hydrocephalus 10 [ ]
   - Microcephaly 11 [ ]
   - Phenylketonuria (PKU) 12 [ ]
   - Prader-Willi syndrome 13 [ ]
   - Smith-Magenis syndrome 14 [ ]
   - Rett syndrome 15 [ ]
   - Congenital rubella 16 [ ]
   - Other & specify………………………………………………………………………………………………… [ ]

10. Further information ………………………………………………………………………………………………..

…………………………………………………………………………………………………………………………
S. VISION

1. Does the person have a **visual impairment or problem** in her / his eye/s e.g. cataract, short sighted? [ ]
   If YES, specify ………………………………………………………………………………………………………
   ……………………………………………………………………………………………………………………………

2. Is the person **registered blind or partially sighted**? [ ]
   If NO, do you **suspect** the person may have a **problem with her / his vision**? [ ]

3. Has the person ever been **prescribed glasses**? [ ]
   If YES, does she / he **decline to wear prescribed glasses**? [ ]

4. Does the person **follow your movements** around the room when you give them no sound clues / when you move silently? [ ]

5. Does the person **screw up their eyes** when eyes are exposed to bright **sunlight**? [ ]

6. Does the person **react to your smile** (when you do not make any sounds)? [ ]

7. Does the person **reach out for objects** held out in front of them? [ ]

8. Is the person **aware of a spoonful of food** if you move it towards her / his mouth? [ ]
   If person is aware, do you think it is because they **see it rather than smell it**? [ ]

9. Is the person **aware of themselves in a mirror** when 6 feet away? [ ]

10. When was the person’s vision **last tested**? *(Approximate if not exactly known) *[ ]
    Is this **more than 3 years** ago? [ ]
T. HEARING

1. Does the person have a hearing impairment or problem with her / his ear/s e.g. repeated ear infections, deaf? [ ]
   If YES, specify ………………………………………………………………………………………………………
   [ ]
   If NO, do you suspect the person may have a problem with her / his hearing? [ ]

2. Has the person ever been prescribed a hearing aid? [ ]
   If YES, does she / he decline to wear a hearing aid? [ ]
   If YES, when was the hearing aid last reviewed / tested? (Approximate if not known) ………….

3. When was the person’s hearing last tested? (Approximate if not exactly known) ……………………
   Is this more than 3 years ago? [ ]

U. ADDITIONAL INFORMATION

1. Does the person have any other known health problems e.g. hypothyroidism, diabetes? [ ]
   If YES, specify ………………………………………………………………………………………………………
   [ ]

2. If the person has diabetes, does she / he receive any treatment other than tablets / injections? (Please tick)
   Special diet 1 [ ]
   Regular check-up with a GP / hospital / clinic 2 [ ]
   Other (Please specify)………………………………………………………………………………………… 3 [ ]

3. Does the person have any other symptoms or other problems of concern? [ ]

4. Does the person complain of pain or do you suspect, for any reason, she / he has pain? [ ]
   If YES, specify ………………………………………………………………………………………………………
   [ ]

5. Has the person changed in themself in any other way recently, or changed in their behaviour? [ ]
V. HEALTH PROMOTION

1. Does the person smoke? [ ]
   If YES, number of cigarettes smoked per day / or grams / ounces of tobacco smoked per day? …………………………………………………………………………………
   If YES, has the person received advice on how to quit smoking? (Please tick)
   No 0 [ ]
   Yes 1 [ ]
   If indicated, discuss referral
   If NO, has the person ever smoked on a regular basis? [ ]
   If YES, how long ago did the person stop smoking [ ][ ][ ] y [ ][ ][ ] m

2. Is the person regularly exposed to other people’s tobacco in any of these places? (Please tick)
   At home 1 [ ]
   At work 2 [ ]
   At other people’s homes 3 [ ]
   Elsewhere 6 [ ]
   No, in none of these places 7 [ ]

3. Does anyone smoke inside her / his home on most days? (Please tick)
   No 0 [ ]
   Yes 1 [ ]
   If YES, how many people? [ ][ ][ ]
4. Does the person **drink alcohol?**
   If YES, number of units of **alcohol** drunk per week?..................................................
   If **above recommended level** (14 units / week for women, or 21 units / week for men. One unit is
   half a pint of beer, 125 ml of wine, or 25ml of spirit), has the person received **advice on safe**
   **drinking / alcohol reduction?** (Please tick)
   No 0 [ ]
   Yes 1 [ ]
   *If indicated, discuss referral*

5. How often does the person **brush teeth** (Please tick)
   More than once / day 1 [ ]
   Once / day 2 [ ]
   Less than once / day 3 [ ]

6. How would you describe the person’s **dental health** at present? (Please tick)
   Perfectly healthy 1 [ ]
   Some decay 2 [ ]
   A lot of decay (include here if the person has no teeth, or has lost a lot of them) 3 [ ]

7. When did the person last have a **dental check?** (Estimate if not known)............................
   Is this **more than 6 months ago**? (Please tick)
   No, within 6 months 0 [ ]
   Yes, more than 6 months ago 1 [ ]
   *If indicated, discuss dental check*

8. Who is the person’s **dentist?** .........................................................................................

9. What **sort of exercise / physical activity** does the person **enjoy?**...........................................
   ........................................................................................................................................
   ........................................................................................................................................
10. Does the person do any **physical activity which makes her / him sweaty or out of breath**, such as fast walking, heavy housework, gardening, exercise, or sport? *(This should only be recorded as yes if it lasts for at least 15 minutes at a time.)* (Please tick)

No [ ]
Yes [ ]

If **YES**, during the **last 7 days**, **on how many days** did the person do physical activity which made her / him out of breath or sweaty? *(Record the number of days)*

If **YES**, **how much time** on average did the person spend on these activities, **each day**? *(Record the number of minutes per day)*

*If the person does not do 30 minutes of accumulated physical activity on most days of the week, discuss referral to the **GP exercise referral scheme “Live Active”***

11. On average, how many **hours** does the person spend **watching TV, DVDs, videos or on the PC**?

None, does not watch TV [ ]
1 - 3 hours / month [ ]
1 hour / week [ ]
2 - 4 hours / week [ ]
5 - 6 hours / week [ ]
1 hour / day [ ]
2 - 3 hours / day [ ]
4 - 5 hours / day [ ]
6 or more hours / day [ ]

12. In the **last 24 hours** (midnight to midnight), how many **portions of fruit and vegetables** did the person eat? *(Please record the number of fresh or dried fruit, fresh fruit juice (one portion is a small 1/4 pint glass), raw, cooked, tinned, frozen vegetables (exclude potatoes, include pulses and legumes. One portion is a heaped tablespoon, include vegetable lasagne and vegetable curry), salad (one portion is an average sized cereal bowel)*

[ ]

13. **On average**, how many **portions of fresh fruit, fresh vegetables, cooked vegetables, and salad**, does the person eat each day?

[ ]
14. Does the person use recreational drugs?

If YES, specify …………………………………………………………………………………
……………………………………………………………………..………………………………

If YES, has the person received any advice on drug use?

No 0 [ ]
Yes 1 [ ]

If indicated, discuss referral

Gastro-oesophageal reflux disorder (GORD) occurs commonly in people with learning disabilities. It occurs in about 50% of people with severe learning disabilities and 70% with profound learning disabilities or cerebral palsy. It is more likely to be present in people with indicators of abdominal pain (such as a disturbed sleep pattern, or problem behaviours), regurgitation, vomiting, vomiting up blood, regular coughing after eating, or if the person has a borderline or low Hb on blood testing, or has dental erosions. It can be a painful condition, and consequences of it include oesophageal strictures, swallowing problems, and a slight increase in risk for cancer. A normal endoscopy does not mean that the person does not have GORD. Many people with more severe learning disabilities cannot describe the pain they are experiencing. It can be fully treated with tablets.

15. Nurse’s opinion: is the person in a high risk group for GORD (i.e. profound learning disabilities, cerebral palsy, or any of the above symptoms)?

If YES, discuss referral to the person’s GP

Osteoporosis occurs more commonly in persons with learning disabilities than in the general population. It can lead to fractures (broken bones), pain, and physical disabilities. Frail people can sometimes die from the consequences of fractures. Bone density is built up during childhood and early adulthood, and then declines with age. Osteoporosis occurs if bone density was never built up to a high enough level, or if levels fall too rapidly with age. Indicators that a person may have osteoporosis include a history of fracture or repeated fractures, lack of development of secondary sexual characteristics (e.g. breast development / menstruation in women, or beard growth in men), lack of vitamin D (through poor diet or insufficient exposure to sunshine), being malnourished, or insufficient weight-bearing exercise (or being unable to weight-bear), being post-menopausal and not taking HRT, and certain drugs e.g. depro-provera, drugs for prostate cancer, steroids, anti-epileptic drugs. Osteoporosis is both preventable, and treatable, and so it is important both to treat it as early as possible, and to consider treatment for people at high risk of developing it.

16. Nurse’s opinion: is the person in a high risk group for osteoporosis (i.e. they have some of the indicators described above)?

If YES, discuss referral to the person’s GP
17. Does the person have any requirements for sexual health intervention or education? [ ]
   If YES, specify ………………………………………………………………………………………..

   If indicated, discuss referral

18. In the last 12 months, has the person had any kinds of accidents (resulting in injury, or physical harm to the person), which caused the person to see a doctor, nurse, or other health professional, or to need time off work or usual daytime opportunities / activities?
   How many? (Record the numbers of accidents)
   If YES, where did it happen?………………………………………………………………………………
   If YES, what caused it?……………………………………………………………………………………
   If YES, what injuries were caused?……………………………………………………………………
   If YES, could anything have prevented it?…………………………………………………………..

   Consider if any referral is needed to attend to any underlying problems

19. Does the person have Down’s syndrome? [ ]
   If YES, when was her / his thyroid function test last checked?……………………………………
   If YES, is TFT testing in-date (i.e. checked in the last year)? (Cross-check with Part I, page 5)
     No, out-of-date 0 [ ]
     Yes, in-date 1 [ ]

   Check the person’s TFTs at the end of the examination

20. Does the person have any problems with their sleep pattern e.g. takes more than 30 minutes to get to sleep, frequently wakes during the night for more than 30 minutes, or wakes very early?
   If YES, specify ………………………………………………………………………………………

21. Does the person seem too sleepy during the day or fall asleep when he/ she doesn’t want to e.g. watching TV, at the cinema, in a car or sitting talking to someone?
   If YES, is this a problem which affects the person’s lifestyle, or other people? [ ]
   If YES, specify ………………………………………………………………………………………
22. Does the person seem to **sleep at the wrong times**, either staying up late (2-3am) or going to bed early and waking in the early hours (2-3am) or sleeping and waking round the clock?
   
   If **YES**, is this a problem which affects the person’s lifestyle, or other people? [ ]
   
   If **YES**, specify ..............................................................
   
   If any of V20 – V24 suggest a sleep problem, consider referral to the CEDD Clinical Service

23. Does the person sometimes **act a bit strangely while asleep** e.g. sleepwalking, talking, acting out their nightmares, or awaking confused or upset?
   
   If **YES**, is this a problem which affects the person’s lifestyle, or other people? [ ]
   
   If **YES**, specify ..............................................................

24. Is the person a **heavy snorer** e.g. heard outside the bedroom, disturbs others? Has anyone noticed that they stop breathing while they are asleep, or the snoring stops and restarts loudly shortly after?
   
   If **YES**, is this a problem which affects the person’s lifestyle, or other people? [ ]
   
   If **YES**, specify ..............................................................

25. Does the person have any **other health information or health educational needs**? [ ]
   
   If **YES**, specify ..............................................................

26. How many **outdoors coats** has the person? *(Do not include suit jackets, blazers, fleeces.)* [ ]

27. How many **pairs of shoes** does the person own? [ ]
W. IMMUNISATION

Are the following immunisations in-date? (Cross-check with information from Part I, page 4)

1. **Tetanus** *(a total of 5 tetanus injections during the person’s lifetime)* (Cross-check with Part I, page 6) (Please tick)

   - Has not had 5 injections 0 [ ]
   - Has had 5 or more injections 1 [ ]
   - Not known [ ]

   If the person has **NOT** had 5 tetanus injections, indicate why not? (Please tick)

   - Not offered 0 [ ]
   - Person distressed / needle phobia 1 [ ]
   - Immunisation planned 2 [ ]
   - Preparation planned 3 [ ]
   - Preparation in progress 4 [ ]
   - Person refused 6 [ ]
   - Carer refused on person’s behalf 7 [ ]
   - Not known [ ]
   - Other & specify………………………………………………………………………… [ ]

2. **Polio** *(a total of 5 polio immunisations during the person’s lifetime)* (Cross-check with Part I, page 6) (Please tick)

   - Has not had 5 immunisations 0 [ ]
   - Has had 5 or more immunisations 1 [ ]
   - Not known [ ]

   If the person’s polio immunisation is **not complete**, indicate why not? (Please tick)

   - Not offered 0 [ ]
   - Immunisation planned 2 [ ]
   - Preparation planned 3 [ ]
   - Preparation in progress 4 [ ]
   - Person refused 6 [ ]
   - Carer refused on person’s behalf 7 [ ]
   - Not known [ ]
   - Other & specify………………………………………………………………………… [ ]
3. **Flu** (for persons in the **high risk categories** of having cerebral palsy, profound learning disabilities, living in residential homes, nursing homes, long-stay NHS hospital, or supported group living, and / or attending a day centre, having chronic respiratory disease (including asthma), chronic heart disease, chronic renal disease, chronic liver disease, immunosuppression, diabetes, or aged 65 years or over) 
(Please tick)

Is the person in a **high risk category for which flu immunisation** is recommended?

- No 0 [ ]
- Yes 1 [ ]

If **YES**, **date** of most recent immunisation……………………………………………………

If **YES**, has immunisation been given in the last year? *(Cross-check with Part I, page 6)*

- No, not immunised 0 [ ]
- Yes, immunised 1 [ ]

If the person is in a high risk category and has **NOT** had flu immunisation, indicate why not? *(Please tick)*

- Not offered 0 [ ]
- Person distressed / needle phobia 1 [ ]
- Immunisation planned 2 [ ]
- Preparation planned 3 [ ]
- Preparation in progress 4 [ ]
- Person refused 6 [ ]
- Carer refused on person’s behalf 7 [ ]
- Not in high risk category 8 [ ]
- Not known 9 [ ]
- Other & specify………………………………………………………………………………… [ ]
4. **Hepatitis B** (for persons in the **high risk categories** i.e. persons with learning disabilities who have contact with any “care” settings e.g. hospital, day centre, group living, respite care)

The following **protocol** should be followed:

- If a normal primary course was completed (at 0, 1, 6 month intervals) – no further action needed
- If a rapid primary course was completed (over a 2 month period) – then a booster is required after a further 1 year; if this hasn’t been given, or if it’s not known if a booster was given, then refer to the Practice Nurse to give a booster now
- If a primary course was never completed – then refer to the Practice Nurse to give this
- If it’s not known if a primary course was given or not – then take blood for hepatitis B titres and antibodies (i.e. hepatitis B immune status); if the results indicate non-immunity, then refer to the Practice Nurse for a primary course. If you cannot get a blood sample, refer to the practice nurse for a primary course.

Is this person in one of the **high risk categories for hepatitis B**?

If **YES**, date and type of immunisation and any booster…………………………………………

If **YES**, is hepatitis **immmunisation completed**? (Please tick) *(Cross-check with Part I, page 6)*

- No, incomplete or not immunised 0 [ ]
- Yes, immunised 1 [ ]
- Not known [ ]

If **NO** or NOT KNOWN, **follow the protocol above, and check titres and antibodies if indicated**

If the person has **NOT** had hepatitis **immunisation**, indicate why not? *(Please tick)*

- Not offered 0 [ ]
- Person distressed / needle phobia 1 [ ]
- Immunisation planned 2 [ ]
- Preparation planned 3 [ ]
- Preparation in progress 4 [ ]
- Immune status checked and waiting results 5 [ ]
- Immune status checked and >10 IU/ml 6 [ ]
- Known hepatitis infection 7 [ ]
- Person refused 9 [ ]
- Carer refused on behalf of person 10 [ ]
- GP didn’t think it was necessary 11 [ ]
- Not known 88 [ ]
- Not in high risk category 99 [ ]
- Other & specify………………………………………………………………………… [ ]
5. Further information....................................................................................................................
................................................................................................................................................
................................................................................................................................................

X. PAST MEDICAL HISTORY

1. Does the person have any other **past health problems** which have not been discussed so far? E.g. operations or medical problems in the past, jaundice, rheumatic fever ..........................................
................................................................................................................................................

Y. FAMILY MEDICAL HISTORY

Has anyone in the person’s **family** (blood relations) experienced any of the following?

If **YES**, specify the relationship e.g. mother

*If the person has a strong family history, consider whether the person should be considered for any preventative treatment, investigation or advice e.g. breast cancer - mammography, heart disease – dietary advice. Discuss with the G.P., when discussing your findings and summary*

1. Diabetes? Relationship........................................................................................................ [ ]
2. Heart disease, angina, heart attack? Relationship......................................................... [ ]
3. Raised blood pressure? Relationship................................................................. [ ]
4. Stroke? Relationship................................................................. [ ]
5. Breast cancer? Relationship................................................................. [ ]
6. Epilepsy? Relationship................................................................. [ ]
7. Mental ill-health? Relationship................................................................. [ ]
8. Alzheimer’s disease or dementia? Relationship......................................................... [ ]
9. Learning disabilities? Relationship................................................................. [ ]
10. Other health problems or concern & specify .......................................................... [ ]

Z. PHYSICAL EXAMINATION

1. GENERAL

a) Urinalysis
   - Glucose [ ]
   - Protein [ ]
   - Blood [ ]
   - Other & describe ................................................................................................

b) Height, without shoes (in metres and centimeters) [ ] m [ ] cm

c) Weight, without shoes (in kilograms) [ ] kg [ ]

   Body Mass Index = Weight (kg) / Height (m)²

<table>
<thead>
<tr>
<th>Weight category</th>
<th>B.M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
</tr>
<tr>
<td>Normal weight</td>
<td>≥ 18.5 but &lt; 25</td>
</tr>
<tr>
<td>Overweight</td>
<td>≥ 25 but &lt; 30</td>
</tr>
<tr>
<td>Obese</td>
<td>≥ 30</td>
</tr>
</tbody>
</table>

If the person is overweight or obese, consider referring to Slimming it Up, or the Glasgow Weight Management Scheme Levels 3 or 4. Also consider if a Live Active referral would be appropriate.

d) Waist circumference on full expiration (to the nearest millimetre) [ ] [ ] cm [ ] mm

   If this is 88cm or more in women (80 cm or more in Asian women); or 102 cm or more in men (90cm or more in Asian men), consider referral to the Glasgow Weight Management Scheme

e) Blood pressure (Before you take the person’s b.p. mention that [ ][ ][ ]/[ ][ ][ ] you will repeat the measurement later)
2. COMMUNICATION

a) Nurse’s opinion: does the person have special needs related to communication? [ ]

N.B. Indicators may include:
- The person repeats back what is said by others
- The person always talks about a favorite topic / says the same thing repeatedly
- The person answers “yes” to everything
- The person answers “no” to everything
- The person answers “don’t know” to everything
- When offered a choice, the person always chooses the last option
- The person is easily distracted, maybe walking away during conversation
- The person is a “loner” and doesn’t want to join in
- The person changes topic in the middle of a conversation
- The person does not use words

If YES, are communication needs currently being adequately met / has the person recently received or is receiving input from a S&LT?

No special communication needs 0 [ ]
Communication needs are not being met 1 [ ]
Communication needs are being met 2 [ ]

3. MOUTH

a) How many of the person’s teeth are missing (including wisdom teeth)? [ ]
    Or
    How many teeth does the person have (including wisdom teeth)? [ ]

b) How many of the person’s teeth are missing (excluding wisdom teeth)? [ ]
    Or
    How many teeth does the person have (excluding wisdom teeth)? [ ]
c) Does the person have a denture?
   Own teeth 0 [ ]
   Some own teeth, some missing 1 [ ]
   Partial denture 2 [ ]
   Full denture 4 [ ]
   Teeth missing, but does not want / won’t wear a denture 5 [ ]

d) Gingivitis [ ]

e) Other oral problem & specify………………………………………………………………………[ ]

4. BLOOD PRESSURE

If first blood pressure measurement was raised, repeat it now [ ][ ][ ]/[ ][ ][ ][ ]

5. VISION

a) Ocular infection / inflammation [ ] [ ]

b) Strabismus [ ] [ ]

   If YES, specify if divergent, convergent, or not known …………………………………………………
   …………………………………………………………………………………………………………………………

   c) Nystagmus [ ] [ ]

d) Abnormal red reflex [ ] [ ]

e) Acuity - Kay’s pictures at 33 cm [ ][ ][ ][ ][][ ]

   [ ][ ][ ][ ][][ ]

f) Acuity – Kay’s pictures at 3 m [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
g) Kay’s pictures *(Please tick for each eye)*

- Test passed: 0 [ ] 0 [ ]
- Visual impairment: 1 [ ] 1 [ ]
- Possible refractive error / presbyopia (i.e. different scores for e & f): 2 [ ] 2 [ ]
- Difficult to test / unsure of test result: 8 [ ] 8 [ ]
- Not tested: 9 [ ] 9 [ ]

### 6. HEARING

**Otoscopy test result:**

a) Visualisation of drum *(Please tick for each ear)*

<table>
<thead>
<tr>
<th></th>
<th>Left</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canal clear</td>
<td>0 [ ]</td>
<td>0 [ ]</td>
</tr>
<tr>
<td>Wax obscuring drum</td>
<td>1 [ ]</td>
<td>1 [ ]</td>
</tr>
<tr>
<td>Difficult to visualise</td>
<td>8 [ ]</td>
<td>8 [ ]</td>
</tr>
<tr>
<td>Not tested</td>
<td>9 [ ]</td>
<td>9 [ ]</td>
</tr>
</tbody>
</table>

b) Does the person have an ear infection / foreign body in the canal or perforated drum?
   - If YES, please specify …………………………………………………………………………………………………

**Hearing test result:** *(Please use this scoring system for each test, for each ear)*

- Test passed = 0
- Unable to hear = 1
- Test failed but has wax = 6
- Difficult to test / unsure of test result = 8
- Not tested = 9

a) Warblers at 1/2m at a level of 30db / 500Hz
   - Left [ ] Right [ ]

b) Warblers at 1/2m at a level of 30db / 1000Hz
   - Left [ ] Right [ ]

c) Warblers at 1/2m at a level of 30db / 2000Hz
   - Left [ ] Right [ ]

d) Warblers at 1/2m at a level of 30db / 4000Hz
   - Left [ ] Right [ ]
7. PEAK FLOW

a) Explain the procedure and demonstrate the test. Record the peak flow three times with the person standing. (If that is not possible, attempt to measure peak flow with the person seated.)

FEV 1
FEV 2
FEV 3

b) Was the person standing for each of these FEVs?
No 0
Yes 1

b) Was the person’s technique satisfactory?
Yes 1
No 2
No, because the person was seated 3

8. BLOOD PRESSURE

Repeat the blood pressure measurement for everyone

<table>
<thead>
<tr>
<th>Blood pressure category</th>
<th>Systolic blood pressure</th>
<th>Diastolic blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerably raised</td>
<td>&gt; 179</td>
<td>&gt;114</td>
</tr>
<tr>
<td>Moderately raised</td>
<td>160 – 179 (men aged 16 – 49y; women aged 16y +)</td>
<td>100 – 114 (men 16 – 49y; women 16y +)</td>
</tr>
<tr>
<td>Moderately raised</td>
<td>170 – 179 (men aged 50y +)</td>
<td>105 – 114 (men aged 50y +)</td>
</tr>
<tr>
<td>Mildly raised</td>
<td>140 – 159 (men aged 16 - 49y; women aged 16y +)</td>
<td>85 – 99 (men aged 16 - 49y; women aged 16y +)</td>
</tr>
<tr>
<td>Mildly raised</td>
<td>160 – 169 (men aged 50 +)</td>
<td>96 – 104 (men aged 50 +)</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt; 140 (men aged 16 – 49y; women aged 16y +)</td>
<td>&lt; 85 (men aged 16 – 49y; women aged 16y +)</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt; 160 (men aged 50y +)</td>
<td>&lt; 95 (men aged 50y +)</td>
</tr>
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</table>

Lower thresholds are required for persons who additionally have diabetes
9. FEET

a) Physical deformity

   Left [ ] Right [ ]

b) Infection / hygiene need

   [ ] [ ]

c) Toe nail problem

   [ ] [ ]

d) Other foot problem & specify………………………………………………………… [ ] [ ]

10. VULNERABLE ADULT

a) Health professional’s opinion – do you think this person is a vulnerable adult as per adult protection procedures?

   If YES, and they are not in contact with the ALDT, discuss a referral [ ]

11. OTHER IMPORTANT OR RELEVANT FINDINGS ON EXAMINATION

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12. BLOOD TEST PROTOCOL

a) Now check a FBC, U&E, LFT, TFT, cholesterol, and Vitamin D on everyone. Also, follow the blood test protocol (appendix 2 of the show cards and protocols), and take the additional bloods that are indicated. Record here the blood tests checked.

   FBC........U&E........LFT........TFT........Cholesterol........Vitamin D........
   ……………………………………………………………………………………………………………
b) If blood tests were not done, say why not

Person refused 1 [   ]
Carer refused 2 [   ]
Person was unable to co-operate 3 [   ]
Person is needle-phobic 4 [   ]
Unable to get a sample, despite attempts 5 [   ]
Relevant bloods results are in the GP casenotes within the last year, and the 9 [   ]
Blood test protocol does not indicate that any further are required now

c) If no urine sample and no blood glucose level – do BM stix & record result [   ]

END OF EXAMINATION
PART III

SUMMARY & ACTION PLAN
A. VINELAND SCALE (SURVEY FORM) SCORES

<table>
<thead>
<tr>
<th>Domain</th>
<th>Years</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>[     ]</td>
<td>[        ]</td>
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<tr>
<td>Daily Living</td>
<td>[     ]</td>
<td>[        ]</td>
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<tr>
<td>Socialisation</td>
<td>[     ]</td>
<td>[        ]</td>
</tr>
</tbody>
</table>

B. HEARING SUMMARY

1. **Hearing status. (Please tick)**
   - Hearing impairment, hearing corrected by aid(s) / devices 1 [   ]
   - Hearing impairment, and won’t wear aid(s) 2 [   ]
   - Hearing impairment, and current aid(s) / devices may not be optimum 3 [   ]
   - No hearing impairment 4 [   ]
   - Hearing impairment suspected or possible, needs further assessment 5 [   ]
   - Hearing impaired, but had impacted ear wax, so will need retesting 6 [   ]

2. **Clinical decision regarding hearing. (Please tick)**
   - Not referred 1 [   ]
   - Referred for auto-acoustic emission testing 2 [   ]
   - Referred to specialist audiology service 3 [   ]
   - Referred to G.P. / Practice Nurse, & specify why ............................. [   ]

**Indications for referral to G.P. / Practice Nurse / Audiology / Autoacoustic emission test:**

- a. Unable to test [   ]
- b. Unsure of findings [   ]
- c. Possible / probable hearing impairment, not assessed in the last two years [   ]
- d. Ear wax needs removal / softening, and then retesting of hearing [   ]
- e. Possible changes related to ageing [   ]
- f. Down’s syndrome and has not been checked in last three years [   ]
- g. Prescribed hearing aid is broken or lost [   ]
- h. Possible / probable ear pathology, not previously assessed [   ]
- i. Other & specify................................................................. [   ]
### C. VISION SUMMARY

#### 1. Refractive status. *(Please tick)*
- Refractive error / presbyopia, corrected by glasses: 1
- Refractive error / presbyopia, and won’t wear glasses: 2
- Refractive error / presbyopia, and current glasses may not be optimum: 3
- No refractive error: 4
- Refractive error suspected, needs further assessment: 5
- Not sure: [ ]

#### 2. Visual status. *(Please tick)*
- Registered blind: 1
- Visual impairment, not corrected by glasses, not registered blind: 2
- No visual impairment: 3
- Visual impairment suspected, needs further assessment: 4
- Not sure: [ ]

#### 3. Clinical decision regarding vision. *(Please tick)*
- Not referred: 1
- Referred to Caledonian visual sciences: 2
- Advised to self refer to high street optician: 3
- Referred to G.P. & specify why: [ ]

#### Indications for vision / eye referral to G.P. / Optometrist:
- a. Unable to test: [ ]
- b. Unsure of findings: [ ]
- c. Possible / probable visual impairment, not assessed in the last two years: [ ]
- d. Person has diabetes and has not seen optometrist in the last 12 months: [ ]
- e. Person has glaucoma and has not seen optometrist in last 12 months: [ ]
- f. Possible changes related to age: [ ]
- g. Down’s syndrome, not assessed in last 3 years: [ ]
- h. Prescribed glasses are broken, or lost, or may not be optimum: [ ]
- i. Possible / probable eye pathology, not previously assessed: [ ]
- j. Other & specify: [ ]
D. SUMMARY OF HEALTH PROBLEMS KNOWN PRIOR TO THE CHECK

Indications for referral to G.P. / Practice Nurse:

a. Known health problem is not thought to have been reviewed during the last 12 months [ ]
b. Known health problem is becoming more severe / more frequent [ ]
c. Management of known health problem may not be optimum [ ]
d. Drugs for known health problem are possibly causing side effects [ ]
e. Other & specify……………………………………………………………………………………… [ ]

E. CURRENT DRUGS

*Asterix those drugs which may need to be reviewed.*

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Indications for referral to G.P. / Practice Nurse / Learning Disabilities Psychiatrist / Pharmacist:

a. Drug is not thought to have been reviewed during the last 12 months
b. Unclear if drug has been beneficial
c. Drug is possibly not managing health problem optimally
d. Possible drug side effects
e. Polypharmacy for the same health problem
f. Antipsychotic drug with unclear psychiatric diagnosis
g. Antipsychotic drug level above B.N.F. maximum, and not under psychiatric care
h. Thioridazine prescription not yet reviewed
i. Vigabatrin prescription and no visual field test
j. Poor inhaler technique
k. Other & specify…………………………………………………………………………………….

F. SUMMARY OF NEW PROBLEMS / SYMPTOMS IDENTIFIED

Indications for referral to G.P. / Practice Nurse:

a. New health problem / symptom is NOT explained by the person’s pre-existing health problem
b. Exacerbation in symptomatology of a known health problem
c. Risk of osteoporosis
d. Likely presence of gastro-oesophageal reflux disorder
e. Other & specify…………………………………………………………………………………….
G. ROUTINE SCREENING / PROCEDURES

Indications for referral to G.P. / Practice Nurse / Community Nurse:

a. Has not had 5 tetanus / polio immunisations in lifetime
b. Hepatitis B protocol has not been followed for high risk group
c. No flu jab in high risk group
d. Contraception required / check
e. Menopausal symptoms
f. Aged 20 - 60 years; no cervical smear in last 3 years (clinical judgement required)
g. Aged 50 - 70 years, or family history of breast cancer; no mammogram
h. Other & specify…………………………………………………………………………………………………………...

H. EPILEPSY

Indications for referral to G.P. / Epilepsy Nurse / Community Nurse / L.D. Psychiatrist:

a. Epilepsy is poorly controlled, or may possibly not be optimally controlled
b. Epilepsy control has deteriorated
c. Epilepsy is not thought to have been reviewed in the last 12 months
d. Polypharmacy
e. Possible drug side effects
f. Vigabatrin prescription and no visual field test
g. Seizure free for last two years, but still takes AEDs
h. Information / education for the person with learning disabilities
i. Information / education for relative / support workers
j. Need for training in stesolid / midazolam administration
k. Recent onset of epilepsy (i.e. not yet investigated / commenced on AEDs)
l. Other & specify……………………………………………………………………………………………………………
I. MENTAL HEALTH AND PROBLEM BEHAVIOURS

Indications for referral to G.P. / Community Nurse / L.D. Psychiatrist (Glasgow C.E.D.D. Clinical Services)

a. *PAS-ADD Checklist* + additional questions $\geq 2$, unless the nurse has good reason to judge this as not appropriate, or unless the person is already receiving psychiatric care

b. Positive *PAS-ADD Checklist* score for any of the special risk questions, unless already receiving psychiatric care

c. Possibility of a previously unidentified mental illness / dementia

d. Known mental illness is not thought to have been reviewed in the last 12 months

e. Known mental illness has become more severe or distressing / symptoms are exacerbated

f. Problem behaviour not previously assessed / no previous interventions

g. Known problem behaviour has become more severe / frequent

h. Management of known mental illness / problem behaviour may possibly not be optimum

i. Onset of new symptoms / problem behaviour / change in behaviour

j. *Pervasive Developmental Disorder Questionnaire* above cut-off threshold or autistic spectrum disorder suspected

k. Drugs for mental illness are possibly causing side effects

l. High dose antipsychotic drugs (above BNF range), not reviewed in the last 6 months

m. Psychotropic drug polypharmacy, not reviewed in the last 12 months

n. Thioridazine prescription not yet reviewed

O. Other & specify………………………………………………………………………………………………………………………

J. MOBILITY, BALANCE, CO-ORDINATION

Indications for referral to Physiotherapist / Occupational Therapist / G.P. / Podiatrist:

a. Moving or handling problem

b. Problem with wheelchair or seating

c. Difficulty in walking, sitting, standing, or transferring, which is not currently being addressed

d. Other & specify………………………………………………………………………………………………………………………
K. NUTRITION

Indications for referral to G.P. / Dietician / “Slimming it Up” / “Live active” / Glasgow weight management scheme level (GWML 3 or 4):

a. B.M.I. 25 – 34.9, refer to “slimming it up” or “live active”
   
b. B.M.I. 30 – 34.9 and comorbidity (diabetes, heart disease, stroke, hypertension, sleep apnoea, respiratory disease, osteoarthritis, weight loss needed prior to surgery, poor mobility, drug related weight gain, high waist measurements), refer to GWMS level 3
   
c. B.M.I. 35 – 39.9 and comorbidity (as listed above), refer to GWMS level 4
   
d. B.M.I. 35 – 40, refer to GWMS level 3
   
e. B.M.I. > 40, refer to GWMS level 4
   
f. 18.5 < B.M.I. < 20 & unintentional weight loss of 5% or more of body weight
   
g. B.M.I. < 18.5
   
h. Dysphagia, or symptoms suggestive of aspiration e.g. cough, dyspnoea, cyanosis after food
   
i. Fluid intake less than recommended
   
j. Problems with tongue thrust, poor lip closure, drooling
   
k. Problems with vomiting / regurgitation
   
l. Problems with constipation / diarrhoea
   
m. Partial or total nutritional support
   
n. Total parenteral feeding
   
o. Low vitamin D level
   
p. Other & specify ……………………………………………………………………………………………………………………………………………………

L. DENTAL / ORAL HEALTH

Indications for referral to dentist

a. Dental / oral pain
   
b. No routine dental check in the last 6 months
   
c. Gingivitis
   
d. Requires support / advice regarding oral hygiene
   
e. Poor denture fit / dentures are lost or broken
   
f. Other & specify ……………………………………………………………………………………………………………………………………………………
M. COMMUNICATION / SWALLOWING

Indications for referral to S&LT

a. Repeated chest infections / aspiration risk / suggestive symptoms e.g. cough, dyspnoea, or cyanosis after eating
b. Dysphagia
c. Person uses a high-tech communication aid and not reviewed in last two years
d. Person has a significant communication change
e. Person has a communication need which is not currently being met
f. Other & specify

N.B. All referrals to S&LT must be accompanied by the following additional information:

- Does the person have paid support?
- Has the person had a placement breakdown in the last year?
- Is the person in crisis?
- Does the person have significant problem behaviours?
- Has the person her / himself requested a referral to S&LT?

N. FOOT CARE

Indications for referral to podiatrist:

a. Person has diabetes and is not already seeing a podiatrist
b. Person does not have sensation in their feet and is not already seeing a podiatrist e.g. congenital neurological problem, cerebral palsy, acquired neurological problem, stroke
c. Foot, toe or nail problem requiring podiatry
d. Possible need for new or replacement specialist footwear
e. Other & specify

O. CONTINENCE

Indications for referral to Occupational Therapist / Community Nurse / Physiotherapist:

a. Person might benefit from a toileting programme
b. Person might benefit from a continence skill development programme
c. Person might benefit from review of continence aids
d. Other & specify
P. HEALTH PROMOTION

Indications for referral to G.P. / Practice Nurse / Live Active / Community Nurse / Health Educational Programme / Other resource:

a. Alcohol problem  

b. Recreational drug use  

c. Nicotine reduction / cessation programme  

d. Sexual health awareness  

e. Healthy eating awareness  

f. Inactive / exercise awareness, refer to Live Active  

g. Healthy lifestyle after the menopause awareness  

h. Diabetic care / osteoporosis / other chronic illness awareness  

i. Sleep problems  

j. Other & specify…………………………………………………………………………………………………………………………...  

Q. SOCIAL CARE

Indications for referral to Care Manager / Social Worker:

a. Accommodation needs  

b. Respite care needs  

c. Employment / day opportunities needs  

d. Welfare guardian need  

e. Review of benefits  

f. Social isolation / relationship problems  

g. Vulnerable adult  

h. Support package review needed  

i. Carer strain  

j. Other & specify
R. SUMMARY OF ABNORMAL FINDINGS ON EXAMINATION

………………………………………………………………………………………………………….
………………………………………………………………………………………………………….
………………………………………………………………………………………………………….
………………………………………………………………………………………………………….

Indications for referral to G.P. / Practice Nurse:

a. Abnormal urinalysis
b. Blood pressure: systolic > 145 or diastolic > 85 (systolic > 140 or diastolic > 80, if diabetic)
c. Irregular pulse
d. Other & specify ……………………………………………………………………………..[ ]

S. SUMMARY OF REFERRALS

Where applicable, state if the professional referred to works from the Learning Disabilities service or the generic service.

<table>
<thead>
<tr>
<th>Identified need</th>
<th>Referred to</th>
<th>Date of referral</th>
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<tbody>
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</table>

T. SUMMARY OF ANY OTHER ADVICE OR ACTION

………………………………………………………………………………………………………….
………………………………………………………………………………………………………….
………………………………………………………………………………………………………….
………………………………………………………………………………………………………….
U. RECORD OF BLOOD TESTS

<table>
<thead>
<tr>
<th>Indication for blood test</th>
<th>Blood tests indicated</th>
<th>Date of blood test taken / arranged by nurse</th>
<th>Test result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone</td>
<td>FBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyone</td>
<td>U&amp;E</td>
<td></td>
<td></td>
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<tr>
<td>Everyone</td>
<td>LFT</td>
<td></td>
<td></td>
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<tr>
<td>Everyone</td>
<td>TFT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyone</td>
<td>Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyone</td>
<td>Vitamin D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

V. SUMMARY AND ACTION PLAN HAS BEEN DISCUSSED WITH (Name of G.P.)

…………………………………………………………………………………………………………

W. SIGNATURES

………………………………………………………….. (Nurse)

…………………………………………………………. (General Practitioner)

X. DATE (date / month / year)

[     ] [     ] / [     ] [     ] / [     ] [     ]
<table>
<thead>
<tr>
<th>APPENDIX 1: OPTIONAL DRUG SIDE EFFECT CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychotropic drugs</strong></td>
</tr>
<tr>
<td>Dry mouth or thirst</td>
</tr>
<tr>
<td>Sleepiness or lethargy</td>
</tr>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Feeling faint when getting up / standing up</td>
</tr>
<tr>
<td>Fast or irregular heart beat</td>
</tr>
<tr>
<td>Blurred vision</td>
</tr>
<tr>
<td>Altered taste</td>
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<tr>
<td>Weak limbs</td>
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<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Agitation</td>
</tr>
<tr>
<td>Problems passing urine</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
</tr>
<tr>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Diarrhoea</td>
</tr>
<tr>
<td>Tremor</td>
</tr>
<tr>
<td>Stiff arms and legs</td>
</tr>
<tr>
<td>Restlessness</td>
</tr>
<tr>
<td>Abnormal movements of mouth &amp; tongue</td>
</tr>
<tr>
<td>Distorted painful muscles e.g. neck</td>
</tr>
<tr>
<td>Increased salivation</td>
</tr>
<tr>
<td>Increased sweating</td>
</tr>
<tr>
<td>Itchy skin</td>
</tr>
<tr>
<td>Jaundice</td>
</tr>
<tr>
<td>Sunburn</td>
</tr>
<tr>
<td>Skin rash</td>
</tr>
<tr>
<td>Onset of / increase in seizures</td>
</tr>
<tr>
<td>Weight gain</td>
</tr>
<tr>
<td>Oedema</td>
</tr>
<tr>
<td>Menstrual disturbance</td>
</tr>
<tr>
<td>Breast milk production</td>
</tr>
</tbody>
</table>
# APPENDIX 2: PERVERSIVE DEVELOPMENTAL DISORDER QUESTIONNAIRE

(Tick the relevant column for each item)

<table>
<thead>
<tr>
<th></th>
<th>Has not happened in past 12 months</th>
<th>Has been present for most of the time in the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rarely uses eye-to-eye gaze, smiling or facial expression when interacting with others</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Rarely greets others spontaneously</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Rarely looks for or offers comfort or affection at times of distress</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Lacks feeling for others or shows abnormal response to others’ emotions</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Does not share objects or food with others</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Does not share enjoyment or interests with others</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Does not share enjoyment or interests with others</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Compared to peers the person has difficulty in developing friendships and social relationships</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Person has no verbal communication skills</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Delay in or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Repeats the same phrase, word or sound over and over, out of context</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Has difficulty reciprocating in a conversation with others (according to verbal ability)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>13</td>
<td>Misuse of subject e.g. uses ‘you’, ‘he’ or ‘she’, when ‘I’ is meant</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Has attachments to unusual objects</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Has hobbies or interests that seem odd to others (abnormal in content or focus, or intensity and circumscribed nature)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Has preoccupation with part-objects or non-functional elements of play materials (such as their odour, the feel or their surface, or the noise or vibration they generate) e.g. touches, smells or tastes objects inappropriately or with an unusual intensity</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Repetitive behaviour such as hand or finger flapping of twisting, body rocking or spinning</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Routines or rituals performed in a particular sequence</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Becomes distressed over changes in routine or surroundings</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Lack of spontaneous make believe or social initiative play appropriate to developmental level</td>
<td></td>
</tr>
</tbody>
</table>

Have the above features been present since **before 3 years of age**?

- **No**
  - 0 [ ]
- **Yes**
  - 1 [ ]
- **Unknown**
  - 2 [ ]
ACKNOWLEDGEMENTS

We are indebted to Nick Lennox for the use of his original material*, and for his permission to substantially modify it.

We are grateful to the many specialist learning disabilities health professionals employed by NHS Greater Glasgow and Clyde, who made substantial contributions to the develop of the C21st Health Check

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* Lennox, N, et al (1999) Comprehensive Health Assessment Program (CHAP), Developmental Disability Unit, Department of Social and Preventative Medicine, University of Queensland”