

PATIENT INFORMATION

Last Name _____	First Name _____
D.O.B. (Age) _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address _____ _____	
Telephone _____	Medicare Number _____
Fax _____	Email _____

Next of Kin / Guardian _____ Relationship _____

Address _____

Telephone(s) _____ Mobile _____

Fax _____ Email _____

.....
Key Worker (if different from above) _____

Address _____

Telephone(s) _____ Mobile _____

Fax _____ Email _____

.....
General Practitioner _____

Address _____

Telephone(s) _____

Fax _____ Email _____

Specialist _____

Address _____

Telephone(s) _____

Fax _____ Email _____

.....

Other Professionals/Agencies currently involved:

Name of person completing this form and relationship to patient:

Referred by _____

Main reason(s) for referral:

Has a comprehensive health check been done by a doctor in the last 1-2 years?

(e.g. CHAP) yes No

If yes, please give date and name of doctor _____

Level of Intellectual Disability

None Mild Moderate Severe Profound Not known

Cause of intellectual disability (if known):

MAIN HEALTH CONDITIONS/PROBLEMS:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

CURRENT MEDICATIONS

(include over the counter/herbal/complementary/vitamins)

Medication	Dose/ Frequency/commencement date

PREVIOUS MEDICATIONS

Medication	Cessation date/ Reason

ALLERGIES/ADVERSE DRUG REACTIONS:

VISION CHECK: Yes Date _____ Results _____
 No
 Don't know

HEARING CHECK: Yes Date _____ Results _____
 No
 Don't know

DENTAL CHECK: Yes Date _____ Results _____
 No
 Don't know

EPILEPSY:

Any seizures in the past Yes No

Seizure within last 5 years Yes No

If yes, Type(s) of seizures (or description of seizure)

At what age did the seizures start? _____

Frequency of seizures _____

Duration of seizures _____

Date of last Seizure _____

Epilepsy Management Plan Yes (please bring it to the appointment) No

WOMEN'S HEALTH (if applicable):

- | | | | |
|----------------------|------------------------------|-----------------------------|------------------------------------|
| Menstrual Periods | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not known |
| Premenstrual tension | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not known |
| Midcycle Bleed | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not known |
| Painful Periods | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not known |
| Vaginal Discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not known |

Date of last normal menstrual period / /

Pap smear Yes (date / /) No Not known

Mammogram Yes (date / /) No Not known

If yes, results _____

BEHAVIOUR:

Are there any behaviour difficulties Yes No

If yes, please describe in detail

Mood (Please describe)

PAST MEDICAL HISTORY:

Illnesses: _____

Operations: _____

Accidents/Fractures: _____

Other Hospital Admissions: _____

Immunisation:

- | | | | |
|--------------------------|---|-----------------------------|-------------------------------------|
| Diphtheria/Tetanus (ADT) | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Tetanus vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Polio vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Measles | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Rubella (German measles) | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Meningococcal vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Hepatitis A vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Hepatitis B vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Influenza vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Pneumococcal vaccine | <input type="checkbox"/> Yes (last dose __/__/__) | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

Tobacco:

Current smoker: Yes No Amount /day _____

Previous smoker Yes No Amount/day_____ Date ceased _____

Alcohol:

Current Drinker Yes No Amount /day _____

Previous Drinker Yes No Amount/day___ Date ceased _____

Other Substances: Yes No

If yes, please give details _____

CURRENT FUNCTIONAL ABILITIES:

(Please circle all those that are appropriate)

Expressive Communications: smiles/vocalises/points or gestures/signs or uses symbols/words/phrases/sentences/articulation problems

Comprehension: no understanding of speech/understands one part command/understand two part commands (details) _____

Mobility: immobile/rolls/crawls/walks with aid/walks unaided/operates wheelchair

Fine motor: reaches/grasps/holds/transfer/manipulates/none of these

Eating: tube fed/fed by others/feeds with assistance/feeds independently

Bathing: fully dependent/able with assistance/able with supervision/independent

Toileting: incontinent of bladder/incontinent of bowel/requires supervision/continent of bladder/continent of bowel

Community living skills: (e.g. shopping, banking)

Yes No

(Details) _____

Travels independently:

Yes No

(Details) _____

Domestic Skills: (e.g. cooking, cleaning)

Yes No

(Details) _____

Literacy Skills:

Yes No

(Details) _____

Any deterioration in skills or memory?

Yes No

(Details) _____

Eating Problem/Diet:

Chewing Difficulty:

Yes No

Swallowing Difficulty:

Yes No

Chokes when eating or drinking:

Yes No

Regurgitates food or liquids:

Yes No

(If "yes" to any of the above, please give details)

Food Consistency:

Puree Soft

Cut up Normal

Any special Diet?

Yes (describe)

No

Sleep:

Sleeps through the night: Yes No

Day time Sleepiness: Yes No

Snores: Yes No

Details of any other sleep problems:

Physical Activity:

Regular Physical activity? Yes No

Type(s) of activity _____ Hours/week _____

(Details) _____

Is the activity Gentle Medium Vigorous

SOCIAL HISTORY:

Current Residence:

- | | |
|--|--|
| <input type="checkbox"/> Independent (sole) | <input type="checkbox"/> Group Home (other) |
| <input type="checkbox"/> Independent (share) | <input type="checkbox"/> Boarding House/Hostel |
| <input type="checkbox"/> Family Home | <input type="checkbox"/> Large Residential |
| <input type="checkbox"/> Group Home (DADHC) | |

Name of the accommodation/support agency:

Approximate date of arrival at the current residence (if not family home) _____

If in a group home or hostel:

Number of other residents _____

Level of supervision:

24 hours (waking shift)

24 hours (sleeping shift)

Other (details) _____

Work/day placement (1) _____ **Hours/week** _____

Work/day placement (2) _____ **Hours/week** _____

Other regular activities (hours/week) _____

Favourite leisure activities _____

Friendships _____

Last Holiday _____

Frequency of family contact _____

Date of last family contact _____

Respite care

Yes

No

If yes, name of the agency for respite care _____

How often you get respite _____

Future Accommodation Plans _____

Professional	Name	Date last seen	Reason for consultation & Outcome
Dentist			
Dermatologist			
ENT/Audiologist			
Gastroenterologist			
Geneticist			
Neurologist			
Ophthalmologist			
Orthopaedic			
Occupational Therapist			
Paediatrician			
Physiotherapist			
Psychiatrist			
Psychologist			
Rehab. Specialist			
Speech therapist			
Others			

This section needs to be completed by the family (if available). If the family is not available, please provide the reason: _____

FAMILY HISTORY:

Order in the family (e.g. eldest, 2nd, 3rd) _____

Consanguinity (are the parents related eg cousins): Yes No

Has any genetic advice been given? Yes No

(If “yes” please specify) _____

Mother: Name _____ D.O.B. _____

Health _____

Occupation _____

Father: Name _____ D.O.B. _____

Health _____

Occupation _____

Siblings:

Name	DOB (Age)	Health

Maternal Grandmother: Age: ____ **Maternal Grandfather:** Age: ____

Health _____

Paternal Grandmother: Age: ____ **Paternal Grandfather:** Age: ____

Health _____

Spouse/Partner: (Age) ____ Health _____

Children: (Ages/Health) _____

Family history: (Please give details)

Heart Disease _____

High Blood Pressure _____

Diabetes _____

Cancer _____

Intellectual disability/learning problem _____

Depression/other mental health problem _____

Other health problems _____

Birth History:

Assisted Conception: (e.g. fertility drugs,IVF,GIFT) Yes No

(Details) _____

Mother's age at birth ____ Father's age at birth _____

Problems during pregnancy Yes No Don't know

(Details) _____

Gestation (at how many weeks was the baby born) _____ weeks

Problems during labour Yes No Don't know

Was the delivery: normal vaginal delivery

by forceps

by vacuum extraction

by caesarean section

Where was the baby born (hospital/home)? _____

Birth Weight _____ kg Apgar score _____

Was the baby well after birth? Yes No Don't know

(Details) _____

How many days after birth was the baby discharged home? _____

Were there any problems with the baby in the first year of life? (e.g. feeding/sleeping/crying) Yes No Don't know

(Details) _____

Development:

At what age did s/he first,

smile: _____ sit: _____ walk: _____ say words _____

speaking sentences: _____

At what age were developmental problems first diagnosed? _____

Where was it done? _____

What tests were done? _____

EARLY INTERVENTION / EDUCATION

Intervention/School	Commenced	Ceased	Comments

PAST EMPLOYMENTS/DAY PLACEMENTS

Name of Service	Commenced	Ceased	Comments

PAST RESIDENTIAL PLACEMENTS

Name of Service	Commenced	Ceased	Comments

DOCUMENTS CHECK LIST

Please make sure that you send us back the following documents before the appointment.

- Specialist's referral with results of complete physical examination and blood tests

- Past Specialist's report

- Brain scan results if appropriate (films and reports)

- Behaviour intervention plan **OR** comprehensive report from service psychologist/key worker

- Discharge summaries from previous hospital admissions (if any)

- Reports from other disability services assessments

- Questionnaire(s)