SHAID* Clinics, Calvary Health Care Tasmania

*, *Specialist Healthcare for Adults with Intellectual Disabilities*

Individual health and support profile for adult patients with disabilities presenting to hospital

Basic information about patient (Carers to fill in)

Date filled in…… ..

Name and role of person filling this in……

Name			
Date of birth			
Gender			
Address			
Phone number(s)			
Medicare number			
Private insurance			
Type of residence		Religion	
Statutory health attorney name/Person Responsible			
Address			
Phone number(s)			
Support agency			
Name of key person from agency			
Contact of key person			
GP name			
GP address			
GP phone			
Other main drs names and contacts			
24 hour emergency contact person			
Phone			

PHOTO OF PERSON WHEN THEY ARE WELL AND HAPPY

Patient's Manner, Skills and Function (Carers to fill in)

Date filled in…….. ..
Name and role of person filling this in……

Basic Information About Patient as a Person	
General manner	
Likes	
Dislikes	
Special friends	
Activities	
Safety concerns	
Cognitive status	
Family contact	

Baseline Information of Skills						
Type of residence (circle correct)	FAMILY HOME	GROUP HOME	INSTITUTION/ NURSING HOME	HOSTEL	OWN	OTHER
Mobility skills (circle correct)	INDEPENDENT --Steady --Unsteady	NEEDS ASSIST --1 person --2 person	MOBILITY AIDS --Walker --Stick	WHEELCHAIR	NON-AMBULATORY	
Dining/Eating (circle correct)	INDEPENDENT	NEEDS ASSIST	TOTALLY DEPENDENT	FED THROUGH A TUBE	OTHER	
Diet texture (circle correct)	STANDARD	CHOPPED/10c PIECE	MINCED	PUREED	THICKENED LIQUID	
Diet type (describe)						
Swallow risk (describe)						
Position for eating (describe)						
Vision (circle correct)	NORMAL	LOW VISION	BLIND	WEARS SPECTACLES	Comment	
Hearing (circle correct)	NORMAL	HARD OF HEARING	DEAF	HEARING AID	Comment	
Toileting ability (circle correct)	CONTINENT	NEEDS ASSIST OR PROMPTING TO GO	INCONTINENT	CATHETERISED	Comment (eg is there a bowel plan?)	
Medication administration (circle correct)	INDEPENDENT SELF MED	MEDICATION BY STAFF	SPECIAL FORMULATION eg liquid		Comment	
Communication (circle correct)	ABLE TO VERBALISE NEEDS AND UNDERSTAND WELL	SOME DIFFICULTY IN SPEECH; UNDERSTANDS BETTER	UNABLE TO SPEAK, USES FACE & BODY EXPRESSION	USES COMMUNICATION AID	Comment (eg what are the signs for *yes* and *no*)	
Posture and seating (describe)						
Washing and hygiene (circle correct)	INDEPENDENT	NEEDS SUPERVISION	TOTALLY DEPENDENT		Comment	
Other eg safety issues, sleep pattern (describe)	Eg cannot use call bell, needs strap for posture, not aware of water temperature, falls					

Medical history (Carers to fill in)

Date filled in…… ..
Name and role of person filling this in……

Date	Condition	Management/Comment	Managing dr
	Cause of disability		
	Is it progressive or stable		
	Intellectual function		
	Musculoskeletal issues		
	Epilepsy		
	Other neurology		
	Gastrointestinal issues		
	Skin issues		
	Endocrine issues		
	Vision		
	Hearing		
	Cardiac issues		
	Respiratory issues		
	Dental issues		
	Reaction/recovery from anaesthetics		
	Immunisation: Fluvax		
	Pneumovax		
	Hepatitis B		
	Hepatitis A		
	Tetanus		
	Recent weight		
	Allergies		
	Family history		
	Ability to cope with tests		
	Please fill in rest of any medical and surgical history below		
	Special instructions for hospitalisation		

Preferred way of taking medications (describe)……...

Current medication list, including prn (Date of writing this list……)

Medication name	Dose of each single tablet	Breakfast dose	Lunch dose	Dinner dose	Bedtime dose
Eg Bloggs	***10 mg***	***2 tablets***	***1 tablet***	***1 ½ tablets***	***nil***

Tips to improve the hospital stay: I. Preparation by caregivers and support agency

Item to checklist	Yes/No (circle correct)	Comments
Awareness of caregiver well known to patient key role in providing history to health professionals	Yes/no	
Prior assessment of patient vulnerability and safety in hospital setting	Yes/no	
Assessment if patient needs 24 hour support in hospital because of distress, disability or behaviour needs	Yes/no	
Awareness that hospital staff will not provide 24 hour care to patient unless there are medical reasons	Yes/no	
Pre-hospital explicit clarification of resources to provide non-medical in-patient care by caregivers	Yes/no	
Awareness to have home-hospital documentation prepared and medication	Yes/no	
Awareness of role of advocacy but only Statutory Health Attorney can give consent	Yes/no	
Awareness of occupational health and safety concerns of work in hospital setting	Yes/no	
Any other concerns in the hospital setting	Yes/no	

Tips to improve the hospital stay: II. Information that caregivers should seek to obtain

Item to checklist	Yes/No (circle correct)	Comments
Date		
Hospital name		
Name of doctor in charge		
Diagnosis	Yes/No	Details
Inpatient management plan		Details
Inpatient meeting with doctors	Yes/No	Details
Inpatient meeting with charge nurse to clarify role of caregiver/family and nurses	Yes/No	Details
Discharge planning with treating medical team and transport needs; liaise with team	Yes/No	Details
Outpatient follow up plan	Yes/No	Details
Copy of letters to patient's home	Yes/No	No comment required
Notify treating doctors that copy of letters to go to the following doctors, nurses, statutory health attorney (have addresses handy):	Yes/No	No comment required
Have changes in medications been explained to patient and their caregivers; do you have a Green card?	Yes/No	Details
Discharge summary done	Yes/No	No comment required
Are there any changes for allied health team (names and contacts) eg speech therapist physiotherapist occupational therapist dietician nurse psychologist service agency These should be written down in discharge letter	Yes/No	Details
Next appointment	Yes/No	Details
Any comment on difficulties of the hospital stay?	Yes/No	Details

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