**Welsh Health Check for Adults with a Learning Disability and on the Social Services Register –revised 2016**

**M Kerr, RG Jones, M Hoghton, H Houston, J Perry. AK Thapar & J Tomlinson**

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| Date: |  |
| Name: | |
| Marital status: | Ethnic origin: |
| Date of Birth: | Sex: |
| Address:  Tel |  |
| Next of Kin  Tel |  |
| Principal Carer:  Tel |  |

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| **Key Health and Social Care Contacts**: | | |
| Consent to share the review with the carer | **Yes** | **No** |
| Consent to share the review with other named relevant professionals? | **Yes** | **No** |
| **Names of other individuals to whom the review should be sent:** | | |

**This is a good time to ask the carer, person with a learning disability if they have any specific concerns or issues they wish to cover whilst performing the health check**

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| Weight (kg/stone) | Height (meters /feet) |
| Blood Pressure | Urine Analysis |
| Smoke (per day) | Alcohol (units per week) |
| Body Mass Index | (weight in kg / height in m2) |
| Cholesterol has been performed if indicated | &Random Blood glucose if indicated |
| Date of last ECG (risk highest for antipsychotics such as Haloperidol/older antipsychotics, Quetiapine or tricyclic antidepressants) |  |

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| **Immunisation** People with learning disability should have the same regimes as others and the same contraindications apply. A high risk of hepatitis ‘b’ has been seen in population of individuals with learning disability | | |
| Has the patient completed a full course of currently recommended vaccinations? | **Yes** | **No** |
| If No, has the patient been offered the recommended top up vaccinations? | **Yes** | **No** |
| Is the patient included in the annual influenza vaccination programme? | **Yes** | **No** |
| Patient declined / contraindicated | **Yes** |  |

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| **Screening uptake** Where screening cannot be performed due to refusal it can be helpful to support from the community learning disability teams to support the individual through the procedures  **Cervical Cytology** People with a learning disability have same indications for cervical cytology as others. **Note:** Smear could be declined by patient | | |
| Is a smear indicated? | **Yes** | **No** |
| If yes when was last smear? | | |
| When is next due? | **Date:** | |
| Patient declined | **Yes** | |
| **Mammography uptake** This should be arranged in line with national screening programme and as per local practice | | |
| Is mammography indicated and has it been offered? | **Yes** | **No** |
| Performed? | **Yes** | **No** |
| Declined | **Yes** | **No** |
| **Bowel Cancer uptake** This should be arranged in line with national screening programme and as per local practice. | | |
| Indicated and offered? | **Yes** | **No** |
| Performed? | **Yes** | **No** |
| Declined | **Yes** | **No** |
| **Aortic aneurysm uptake** This should be arranged in line with national screening programme and as per local practice. | | |
| Indicated and offered? | **Yes** | **No** |
| Performed? | **Yes** | **No** |
| Declined | **Yes** | **No** |

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| **Chronic Illness** | | |
| Does your patient suffer from any chronic illness? | **Yes** | **No** |
| If yes please specify: | | |

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| **Systems Enquiry** | | |
| **Respiratory Be especially concerned if frequent chest infections as these can indicate that swallowing is impaired and referral needed Number of chest infections in previous 12 months:……………..** | | |
| Persistent cough | **Yes** | **No** |
| Haemoptysis | **Yes** | **No** |
| Abnormal sputum | **Yes** | **No** |
| Wheeze | **Yes** | **No** |
| Dyspnoea | **Yes** | **No** |

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| **Cardiovascular system** | | |
| Chest pain | **Yes** | **No** |
| Swelling of ankles | **Yes** | **No** |
| Palpitations | **Yes** | **No** |
| **Paroxysmal** nocturnal dyspnoea | **Yes** | **No** |
| Cyanosis | **Yes** | **No** |

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| **Abdominal Be aware of possibility of unrecognised reflux oesophagitis as a cause weight loss, sleep disturbance or dyspepsia** | | |
| Constipation | **Yes** | **No** |
| Weight loss | **Yes** | **No** |
| Diarrhoea | **Yes** | **No** |
| Dyspepsia | **Yes** | **No** |
| Melaena | **Yes** | **No** |
| Rectal bleeding | **Yes** | **No** |
| Faecal incontinence | **Yes** | **No** |
| Feeding problems | **Yes** | **No** |

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| **C.N.S. – for epilepsy see below** | | |
| Faints | **Yes** | **No** |
| Parasthesia | **Yes** | **No** |
| Weakness | **Yes** | **No** |

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| **Genito-urinary** | | |
| Dysuria | **Yes** | **No** |
| Frequency | **Yes** | **No** |
| Haematuria | **Yes** | **No** |
| Urinary Incontinence | **Yes** | **No** |
| If Yes has M.S.U. been done | **Yes** | **No** |
| Have other investigations been considered? | **Yes** | **No** |

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| **Gynaecological** | | |
| Dysmenorrhoea | **Yes** | **No** |
| Inter menstrual bleeding | **Yes** | **No** |
| PV discharge | **Yes** | **No** |
| Is patient post menopausal? | **Yes** | **No** |
| **Contraceptives** | | |
| **Needed** | **Yes** | **No** |
| **Used** Note: Oral, Intra-uterine device, Depot, Transdermal, Subcutaneous, Diaphragm, Contraceptive sponge, No contraception | **Yes** | **No** |
| Other **Note:** e.g. PMT, pregnancy | | |

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| **Epilepsy Note**: Consider specialist review if no review in last 3 years | | | **Yes** | | **No** |
| Date of last specialist appointment: Less than 3 years | | | **Yes** | | **No** |
| Greater than 3 years | | | **Yes** | | **No** |
| **Type of fit:** | | | | | |
| Focal seizures: simple partial, complex partial or secondary generalised | | | **Yes** | | **No** |
| Generalised seizures: absence seizures, myoclonic, clonic, tonic, tonic-clonic or atonic | | | **Yes** | | **No** |
| Unclassified seizures | | | **Yes** | | **No** |
| Frequency of seizures (fits/month) | | | | | |
| Over the last year have the fits | **Worsened** | **Remained the same** | | **Improved** | |
| Antiepileptic medication | | | | | |
| Name Dose/frequency Levels (if indicated) | | | | | |
| Side effects observed in the patient | | | | | |

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| **Presence of Behavioural and Mental ill health Note:** Behavioural disturbance in people with a learning disability is often an indicator of other morbidity. For this reason it is important to record it as it can point to other morbidity.  The presence of behavioural or emotional change when physical illness has been excluded warrants referral to learning disability services  It is always good practice when concerned about a person with a learning disability to try and talk to them on their own to see if there are stresses or concerns they don't want to discuss in front of carers | | |
| Has there been a change in behaviour since the last review: e.g. aggression, self-injury, over-activity. | **Yes** | **No** |
| Are you aware of any risk or change in the level of risk to the patient or others? | **Yes** | **No** |
| If yes, has this been communicated to key health and social care professionals? | **Yes** | **No** |
| Does the person have a recorded mental illness? | **Yes** | **No** |
| If so is the person on medication for this? | **Yes** | **No** |
| Are there possible signs or concerns over the known mental illness or the possibility of a new condition? | **Yes** | **No** |

You may consider referral to mental health services to address this

**General appearance**

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| Are there any abnormal physical signs or key negative findings. | **Yes** | **No** |
| If yes please specify: | | |

**Cardiovascular System**

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| Are there any abnormal physical signs or key negative findings | **Yes** | **No** |
| If yes please specify: | | |
| Pulse (beats/min) Regular Irregular | | |
| Blood pressure | | |
| Ankle Oedema | **Yes** | **No** |
| Heart sounds (? describe) Murmurs/ added sounds Yes No | | |
| Patient declined | **Yes** | |

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| **Respiratory system** | | |
| Are there any abnormal physical signs or key negative findings | **Yes** | **No** |
| If yes please specify: | | |
| Patient declined | **Yes** | |

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| **Abdomen** | | |
| Are there any abnormal physical signs or key negative findings | **Yes** | **No** |
| If yes please specify: | | |
| Patient declined | **Yes** | **No** |

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| **Dermatology** | |
| Any signs or symptoms | **Yes** |
| Diagnosis | |
| Patient declined | **Yes** |

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| **Breast** | | |
| Are you aware of any breast symptoms or signs | **Yes** | **No** |
| If yes, please indicate what action has been taken: | | |
| **Note:** If no, please indicate why (e.g. consent issues) | | |
| Patient declined | **Yes** | |

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| **Testis** | | |
| Has an examination of testis been performed | **Yes** | **No** |
| Patient declined | **Yes** | |

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| **Central Nervous System** |
| **Note:** It is often difficult and not relevant to perform a full neurological examination, however, people with a learning disability are particularly prone to abnormalities in vision, hearing and communication – a change in function would suggest further investigation is necessary |

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| **Presence of vision difficulties** | | |
| **Does the patient appear to have eyesight problems e.g. eye rubbing?** | **Yes** | **No** |
| Normal vision? **Note:** include normal vision corrected with glasses/ contact lenses | **Yes** | **No** |
| Minor visual problem? | **Yes** | **No** |
| Major visual problems? Note: include registered blind | **Yes** | **No** |
| Is the carer/key worker concerned? | **Yes** | **No** |
| **Recommend the carer takes the patient to an optometrist** | **Yes** | **No** |
| Is there a cataract? | **Yes** | **No** |

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| **Presence of hearing difficulties** | | |
| Normal hearing? | **Yes** | **No** |
| Minor hearing problem? | **Yes** | **No** |
| Major hearing problem? | **Yes** | **No** |
| Is the carer/ key worker concerned? | **Yes** | **No** |
| Does he/she wear a hearing aid? **Note:** if no has he/she been fitted for a hearing aid? | **Yes** | **No** |
| Any wax? | **Yes** | **No** |
| Does your patient see an audiologist? | **Yes** | **No** |
| Other investigation | | |
|  Has the patient ever had a hearing screen?  For those aged 40 and over, has the patient had a hearing screen within the past 3 years?  For those with Down’s syndrome (regardless of age), has the patient had a hearing assessment with the past 3 years? | | |

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| **Presence of communication difficulties** | | |
| Does your patient communicate normally? | **Yes** | **No** |
| Does your patient communicate with aids? **Note:** e.g. writing pad, signing | **Yes** | **No** |
| Does your patient have a severe communication problem? | **Yes** | **No** |
| Does your patient see a speech therapist? | **Yes** | **No** |
| Where communications problems exist have practice staff been made aware & medical record tagged? | **Yes** | **No** |

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| **Presence of mobility difficulties** | | |
| Is your patient fully mobile? | **Yes** | **No** |
| If no, please specify nature and severity of mobility loss such as presence of contractures e.g. uses a wheelchair, walking stick, walking frame, crutches, splints, surgical boots | | |
| Has there been any change in mobility and dexterity of patient since the last review? | **Yes** | **No** |
| If yes, please specify: | | |

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| **Other Investigations** | | |
| Are there any further investigations necessary? | **Yes** | **No** |
| If yes please indicate | | |

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| **Syndrome Specific Check** | | |
| **Note:** Certain syndromes causing learning disabilities are associated with increased morbidity for this reason it is important to record: | | |
| Is the cause of learning disability known? | **Yes** | **No** |
| If yes, what is it? | | |
| Has the patient had a genetic investigation? | **Yes** | **No** |
| Result? | | |
| If your patient has Down’s syndrome he/she should have a yearly thyroid profile | | |
| Has this been done? | **Yes** | **No** |
| If your patient has Down syndrome please ask family members, carers or care workers (as appropriate) about any changes that might suggest the need for an assessment of dementia, such as: | | |
| Any change in the person's behaviour | **Yes** | **No** |
| Any loss of skills (including self-care) | **Yes** | **No** |
| A need for more prompting in the past few months | **Yes** | **No** |
| **Have a low threshold for excluding concurrent physical morbidity and or referral to mental health services** | | |

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| **Medication Review** | | |
| Is the person antipsychotic medication without a recorded mental health illness? | Yes | No |
| Could any of the psychotropic medication be reduced or stopped? | Yes | No |

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| **Drug** | **Dose** | **Side Effects** | **Levels (if indicated)** |
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| Please list the key findings from the medication review. | | | |

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| **Actions** |
| Please list the actions that have arisen as a result of the medication review and indicate how these have been dealt with. |

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| **Every year the patient should have a review by a dental practitioner – has this been done?** | **Yes** | **No** |
| **Every year the patient should have a review by an optometrist – has this been done?** | **Yes** | **No** |
| Has a summary letter with appropriate responses been sent to the patient or carer? | **Yes** | **No** |
| Has a copy of the letter been sent to the community learning disability team if involved? | **Yes** | **No** |