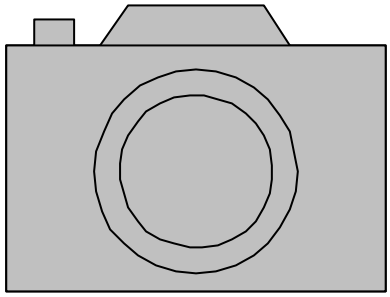
RESIDENTIAL SERVICES FOR PERSONS WITH DISABILITIES
HEAD TO TOE ASSESSMENT
2019

My Comprehensive Health Check

Name: _____

Date of Health Check: _____



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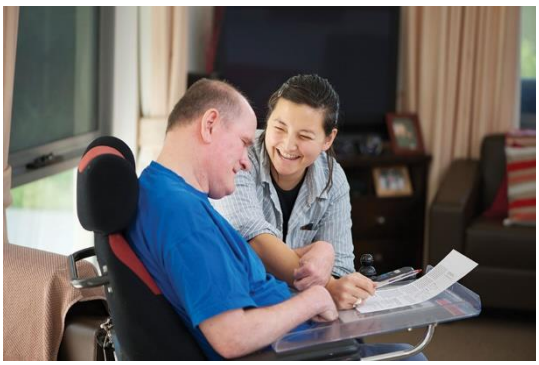
My Comprehensive Health Check

1 Having a health check

Health checks are very important so that we stay healthy.

We should have a health check once a year.

This is your health check.



You will be asked about your health and how you feel.

	You will be asked to tell us if you have any problems with your health.
	It is very important to keep a record of your health and take care of anything that might be causing you a problem.
	Your records are private and will be kept safe. Only your care team will see your record.

The first part of the health check is to ask you about yourself, who your doctor is and who supports you. It is ok if you do not know all the information. Is it ok if I ask others, we may need to ask the nurse or the doctor to help.

2. My Personal Details:

My Name:_____Male/Female (please mark)

My Date of Birth:_____

Unique Identifier: _____

My Address:_____

My Residential Service I link with:_____

Date of my health check:_____

The name of person completing assessment with me: _____

The people who contributed to my health and personal care assessment:

_____

_____

_____

_____

My GP's name is_____

Name of last GP (if changed in the last year)_____

Is there access to my medical records Yes No
If you have a name for your disability please add it here: _____

_____

Additional Comments:

_____

_____

_____

Now I would like to ask you some questions about you and your families' health. Is this OK?

3. Family History; Does any of your close family (Father, Mother, Brother or Sister) have any of the following?

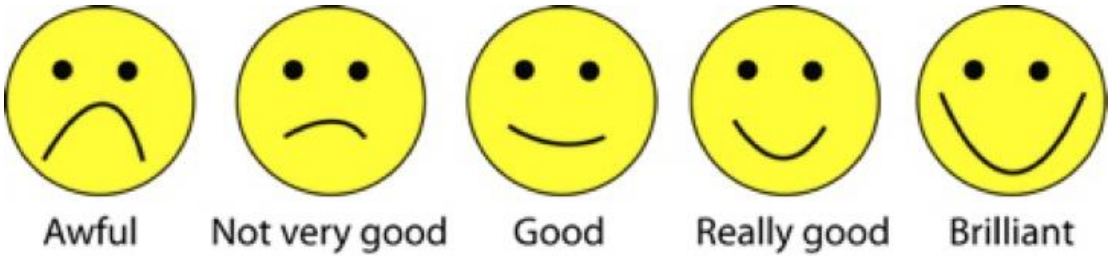
	Yes	No	Don't Know
Asthma			
Osteoporosis			
Diabetes			
Epilepsy			
Glaucoma			
Heart Problems			
Blood Pressure			
Cancer or history of cancer			

Now I would like to ask you about the immunisations you have had, it is ok if you do not know

4. Immunisations I have had			
Name of immunisation	Date	Relevant test	Booster dates
Flu			
Hepatitis A			
Hepatitis B			
Pneumonia			
Tetanus			
Any other please tell us			

Please note the action to be taken from this section: **1. If yes for family history this needs to be referred to the nurse/ public health nurse/ practice nurse/ GP** **2. If these are unknown or no these need to be flagged and undertaken** **In services where there are no nursing access this form is used to identify gaps for attending the GP**
If dates of vaccinations are unknown please state 'unknown' clearly, do not leave blank*

Now I would like to ask you questions about how you feel about your health

5. My Feeling about my health
Choose a picture that tells me how you feel about your health? 
Are there things we can do to help you feel better? Tell us….

Please list any actions to be taken from this section:

The next questions are about your body.

6. My Body		
	Yes	**No**
Are you happy with your weight?		
Have you noticed any changes in your weight recently?		
If yes, please tell me more...		
My Height is		
My Weight is		
My Waist measurement is (see appendix 1 for the meaning of measurement ranges)		
Please calculate my BMI (see how to in appendix 2 of this document)		
Please list the results if any of my measures are outside the normal range. This will help us know what to do next		

Now I will ask you some questions about your medicines

7. My medicines	Yes	No
Do you take medicines? This includes what your doctor tells you to take and what you can buy in the shop, for example pain killers, vitamins, cough medicine or other **Note to assessor: If no, skip this section**		
Has your medicines been reviewed in the last 3 months? Yes ☐ No ☐		
Please list any actions to be taken. **Ref to guidance doc**		

Now I would like to ask you if you are allergic to anything.

8. Allergies
Do you have allergies or are you sensitive to anything like medicines, food, drinks, washing powder or anything else? Yes: ☐ No: ☐ **Note to assessor: If no skip this section**
If yes please tell us…
The cause of your allergy or what you are sensitive to:

The reaction you get: (example rash, swelling)
Please list any actions to be taken from this section? NB Ensure medication allergy is indicated on prescription record and hospital passport as appropriate.

9. My hair, nails and skin.

Now I am going to ask you some questions about your hair nails and skin,

My hair
In the last while have you noticed anything different about your hair condition for example are you losing any hair, is your scalp itchy or dry? Yes ☐ No ☐
My nails
In the last while have you noticed any changes in your nails for example if they break easily, are sore or different colour to usual? Yes ☐ No ☐
My skin
In the last while have you noticed any changes to your skin for example any spots, pimples or lumps you haven't noticed before? Yes ☐ No ☐
Does your bottom, elbows or heels get sore when you sit for a long time? Yes ☐ No ☐
Do you bruise easily?

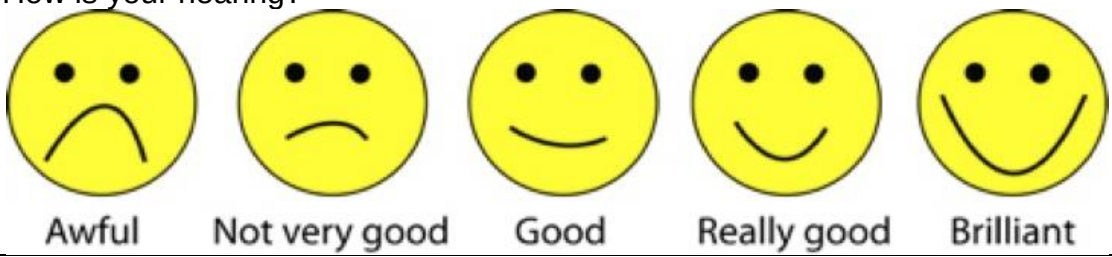
Yes ☐	No ☐
Please note any actions to be taken from this section	

10. My eyes, ears, mouth, nose and throat

Now I am going to ask you some questions about your eyes, ears, mouth, nose and throat

My eye sight
How is your eye sight? 
Do you have any problems with your eyes? For example do you have sore, itchy, sticky eyes or eyelids? Yes ☐ No ☐
Can you see things clearly far away from you and near to you? For example can you see the television clearly or look at a picture or writing in a book **Far away:** **Near:** Yes ☐ No ☐ Yes ☐ No ☐
Do you ever bump into things because you did not see them as you were walking past? Yes ☐ No ☐

Do you wear glasses or contact lenses? Yes ☐ No ☐
Have you had an eye test recently? Yes ☐ No ☐
If yes, Do you know when that was? _____ If No, annual eye test needed. (Red flag for action)
Have you had retinal screening? Yes ☐ No ☐
Any other problems with your eyes, please tell us?
Please list any actions to be taken from this section

My ears and my hearing
How is your hearing? 
Do you have any problems with your ears or hearing? For example have you any difficulty hearing what people are saying to you or when you are in a group? Yes ☐ No ☐

Do you have any problems with wax soreness, itchy ears or do you need to continuously rub your ears? Yes ☐ No ☐
Do you get buzzing in your ears? Yes ☐ No ☐
Do you wear a hearing aid? Yes ☐ No ☐
Have you had a recent hearing test? Yes ☐ No ☐
Do you know when that was? Yes ☐ No ☐
Is there anything else about your ears and hearing that you want to tell us about?
Please list any actions to be taken from this section

My mouth, teeth and gums
Do you have teeth? All my own ☐ Some of my own ☐

None of my own ☐

Do you have any problems with your tongue or teeth or gums? For example do you have any pain when you eat, do you feel any pain when drinking anything very hot or cold, is your mouth very dry or do you grind?

Yes ☐ No ☐

Do you ever get mouth ulcers or sores in your mouth?

Yes ☐ No ☐

Do your gums bleed when you brush your teeth?

Yes ☐ No ☐

Do you wear dentures and/or have you any crowns?

Yes ☐ No ☐

Do you go to the dentist regularly?

Yes ☐ No ☐

Do you know when that was?

Date: _____

Please list any actions to be taken from this section

My Nose

Do you have any problems with your nose? For example do you ever get a sore nose or nose bleeds?

Yes ☐ No ☐

Do you often get a blocked or runny nose?

Yes ☐ No ☐

Do you have difficult in smelling or tasting things?

Yes ☐ No ☐

Please list any actions to be taken from this section

My throat

Do you have any problems with your throat? Get a lot of sore throats?

Yes ☐ No ☐

Do you have difficulty swallowing?

Yes ☐ No ☐

Do you have any thyroid problems?

Yes ☐ No ☐

Do you feel the cold a lot?

Yes ☐ No ☐

Do you ever get tightness or swelling in your throat?

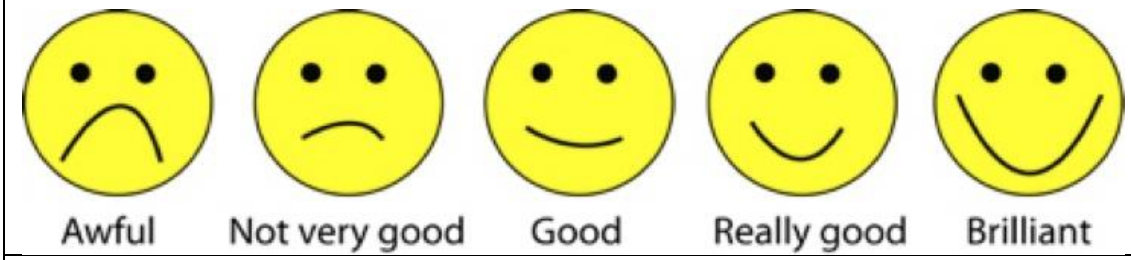
Yes ☐ No ☐

Please list any actions to be taken from this section

Now I would like to ask you about your mental and emotional health?

11. My mental and emotional health

How do you feel in the last 3 months?



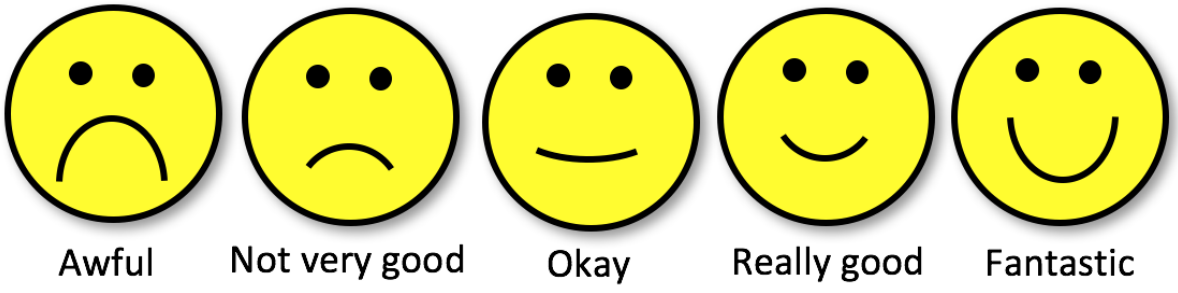
Do you have a doctor's diagnosed mental health condition? For example depression or anxiety

Yes ☐ No ☐

In the last year, have you seen any of the following people? Please tick all that apply

	Yes	Date when last seen
A Psychologist		
A Psychiatrist		
A Positive behaviour therapist		
A Counsellor		
A Clinical nurse specialist		
Other , please tell us		

How well do you sleep in the last 3 months?



Do you find it hard to stay awake during the day?

Yes ☐ No ☐
Do you ever experience night sweats? Yes ☐ No ☐
Please list the actions to be taken from this section

Now I would like to ask you about pain

12. Pain
Do you often get pain? Like headaches or stomach pains Yes ☐ No ☐
If yes, tell us more about your pain
Have you had a pain assessment? Yes ☐ No ☐
Please list the actions to be taken from this section

Now I would like to ask you about your memory

13. My Memory
Do you often forget where you put things? Yes ☐ No ☐

Do you often forget the names of people you know well? Yes ☐ No ☐
Have you ever seen a doctor about your memory? Yes ☐ No ☐
Have you ever had a memory assessment? Yes ☐ No ☐
Please list the actions to be taken from this section **Note to assessor:** *Indications for doing a baseline screening dementia assessment: • *If the person is over 35 and has Down syndrome* • *If the person is aged 50 years or over and has intellectual disability or other aetiology or has experienced changes in the last 6 months a baseline assessment is required.*

Now I would like to ask about epilepsy

14. Epilepsy
Do you have epilepsy? (seizures) Yes ☐ No ☐ **Note to assessor: if no, skip this section**
If Yes, have you had a specialist assessment? Yes ☐ No ☐
When did you have your last seizure?

Date: _____
When were you last seen about your epilepsy? Date: _____
Who did you see? EG. Clinical nurse specialist, Doctor, Neurologist; Please tell us. _____ _____ _____
Do you have a support plan to help you with your epilepsy? Yes ☐ No ☐ If no, support plan is needed.
Please list the actions to be taken from this section

15. My Breathing and Circulation

Now I would like to ask you some questions about your breathing and circulation.

My breathing
Do you have any problems with your breathing, for example do you get breathless when walking? Yes ☐ No ☐
Do you have a chronic breathing condition (something you have had for a while for example asthma) Yes ☐ No ☐
Please list the actions to be taken from this section

My Circulation

Do you have

High blood pressure Yes ☐ No ☐

Low blood pressure Yes ☐ No ☐

What is your usual BP _____

When was your blood pressure checked last? _____

What is your pulse rate, blood pressure at rest

Pulse ☐

Blood pressure ☐

Note to staff if no BP records the BP needs to be taken

Do you have chronic circulatory problem for example swollen ankles, cold hands and/or feet?

Yes ☐ No ☐

Do you have bulging or varicose veins on your legs?

Yes ☐ No ☐

Have you had your cholesterol level checked?

Yes ☐ No ☐

When was your cholesterol checked last?

Date: _____

Please list the actions to be taken from this section

Now I would like to ask you some questions about your digestion

16. My digestion
Do you have a problem with your digestion for example heartburn or indigestion? Yes ☐ No ☐
Do you have a chronic digestive condition for example celiac or Crohns? Yes ☐ No ☐
Do you have any problems eating or swallowing your food and/or drinks? Yes ☐ No ☐

My Bowel Health	Yes	No
Do you have regular bowel movements?		
Do you ever get constipated?		
Do you get any discomfort, pain or bloating in your stomach?		
Do you ever bleed from your back passage after going to the toilet?		
Do you have piles?		
Have you ever had a bowel screen? If yes, date:_____		

Please list the actions to be taken from this section

17. Female Health

Now I would like to ask you some private questions about your female health.

Some private questions about your female health
Have you any problems with your breasts for example lumps, bumps or spots? Yes ☐ No ☐
Do you check your breasts regularly? Yes ☐ No ☐
Have you had a breast check? If yes, date: _____
Do you have regular periods? Yes ☐ No ☐
Have your periods changed recently for example lighter or heavier? Yes ☐ No ☐
Have you started the menopause yet? Yes ☐ No ☐
If yes are you on medicines for this? Yes ☐ No ☐
Have you had a cervical smear? Yes ☐ No ☐ If yes, Date_____
Do you ever get itching, discomfort or unusual discharge from your private parts? Yes ☐ No ☐
Are you in a relationship? Yes ☐ No ☐

Please list the actions to be taken from this section

18. Male Health

Now I would like to ask you some private questions about your male health.

Some private questions about your male health
Do you have any problems with your private areas for example swelling, soreness or discharge? Yes ☐ No ☐
Do you have a prostate problem for example difficulty passing urine or slow to start, can't go sometimes, or dribbling? Yes ☐ No ☐
Have you had a blood test for your prostate recently? Yes ☐ No ☐ Date: _____
Have you seen a doctor about your private area recently? Yes ☐ No ☐ Date: _____
Do you ever have problems with itching, or unusual discharge in your private areas? ☐ ☐

Yes No
Are you in a relationship? Yes ☐ No ☐
Please list the actions to be taken from this section

Now I would like to ask you some questions about using to the toilet

19. My urinary health
Do you have any problems with passing urine for example pain or stinging or burning? Yes ☐ No ☐
Have you noticed any unusual smell from your urine or an unusual colour? Yes ☐ No ☐
Do you have any problems staying dry during the day? Yes ☐ No ☐
Do you have any problems staying dry during the night? Yes ☐ No ☐
Have you had a continence assessment recently? Yes ☐ No ☐ Date: _____

Please list the actions to be taken from this section

20. Mobility, Bones, Joints and Feet

Now I would like to ask you some questions about your mobility, bones joints and feet.

My mobility
Do you need supports with your mobility for example do you need assistance with getting around safely or getting up from a chair or bed? Yes ☐ No ☐
Do you use anything to help you get around like a stick, scooter or wheelchair? Yes ☐ No ☐ If yes what do you use? _____
Do you use a hoist? Yes ☐ No ☐
Do you ever get pain when you are moving about for example getting up from a chair or bed? Yes ☐ No ☐
Do you have any problems with your back like pain or difficulty standing up straight? Yes ☐ No ☐
Have you had a fall in the last 6 months Yes ☐ No ☐

Are you afraid you might fall?

Yes ☐ No ☐

Have you had a falls assessment recently?

Yes ☐ No ☐

If yes, Date: _____

Have you seen anyone recently in relation to your mobility for example a doctor or physiotherapist?

Yes ☐ No ☐

If yes, Date: _____

Please list the actions to be taken from this section

My Bones and joints

Do you have any problems with your muscles or joints? For example arthritis or swelling of your joints such as the knees or elbows.

Yes ☐ No ☐

Have you osteoporosis (brittle bones)?

Yes ☐ No ☐

Have you broken any bones recently?

Yes ☐ No ☐

Have you had a DXA scan?

Yes ☐ No ☐

If yes, Date: _____

Are you taking any of the following medicines	**Yes**	**No**
Anti – epileptic medicines		
Medicines for your mental health		
Medicines for your stomach		

Please list the actions to be taken from this section

My feet
Do you have any problems with your feet? For example ingrown toe nail, corns or bunions Yes ☐ No ☐
Do you have any pain in your feet or toes? Yes ☐ No ☐
Do you ever have very cold feet? Yes ☐ No ☐
Do you have diabetes? Yes ☐ No ☐
Have you had a foot assessment? Yes ☐ No ☐
Have you seen a chiropodist recently Yes ☐ No ☐ If yes, Date _____
Please list the actions to be taken from this section

21. Summary

Please summarise actions from each of the sections in the health check.

Section	Action to be taken Yes or No
My personal details	
My family's health	
Immunisation	
My body	
My medicines	
Allergies	
My feelings about my health	
My hair	
My nails	
My skin	
My eyesight	
My ears and my hearing	
My mouth teeth and gums	
MY nose	
My throat	
My mental and emotional health	
Pain	
My memory	
Epilepsy	
My breathing	
My circulation	
My digestion	
My female health	
My male health	
My urinary health	
My mobility	
My bones and joints	
My feet	

Appendix 1 BMI and Waist Circumference Cut Off Points
(World Health Organisation)

	Body mass index	Obesity class	Disease risk (relative to normal weight and waist circumference)	
			Men < 102 cm Women < 88 cm	Men >102 cm Women >88 cm
Underweight	<18.5			
Normal	18.5–24.9			
Overweight	25.0–29.9		Increased	High
Obesity	30.0–34.9 35.0–39.9	I II	High Very high	Very high Very high
Extreme obesity	>40.0	III	Extremely high	Extremely high

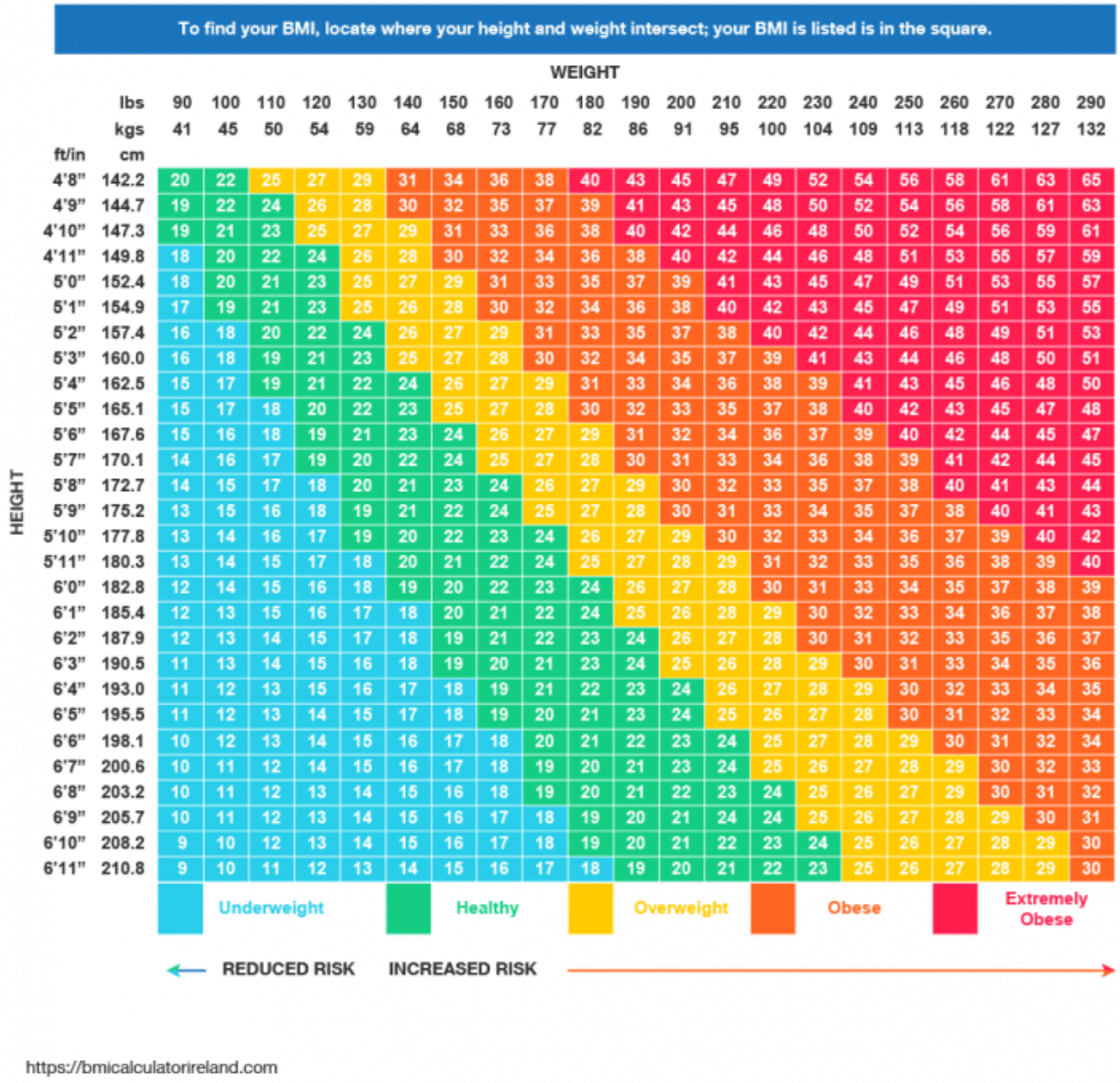
Source: NHLBI Obesity Education Initiative (2000)

World Health Organization cut-off points and risk of metabolic complications

Indicator	Cut-off points	Risk of metabolic complications
Waist circumference	>94 cm (M); >80 cm (W)	Increased
Waist circumference	>102 cm (M); >88 cm (W)	Substantially increased
Waist–hip ratio	≥0.90 cm (M); ≥0.85 cm (W)	Substantially increased

M, men; W, women

Appendix 2 Calculating BMI



https://bmicalculatorireland.com

Signed by the person.....Date .....

Signed assessor.....Date.....

Signed supervising manager.....Date .....

Guidance document to support head to toe assessment

May 2019

Introduction

This guidance has been developed to support an assessor in completing the Health Check with a person whom he/she is supporting. It will guide the assessor to a link where further information may be obtained that relates to that particular part of the health check.

The Health Check is designed to be administered by any member of staff who is supporting an individual with a disability. In the case where the staff member believes that the response to any particular question is outside of their scope of practice, knowledge or remit, the appropriate action would be to report the finding of the assessment to the nurse or house parent/line manager, for follow up.

The nurse would then carry out the necessary assessments highlighted such as falls assessment or skin integrity etc. In the case where a service does not have access to a nurse, the house parent/line manager would organise the necessary assessments with the visiting nurse (if available or public health nurse) and/or refer to the GP.

The information generated in this Health Check will be used to inform the individual's Health Passport which is a document for people with an intellectual disability to be used when they are in contact with a healthcare setting. The Health Passport should be read in order to make reasonable adjustments before staff in a healthcare setting undertake any assessment, examination, treatment or care.

1. Having My health check

The person undertaking your health check will explain the form to you

2. Your personal details

This section to be competed in full

3. Your family's history

If any of your responses are YES to Family health –this needs to be referred to nurse/public health nurse/practice nurse/GP.

4. Your Immunisation history

If dates of vaccines are unknown ,please state 'unknown' clearly-DO NOT LEAVE BLANK Consult GP www.immunisations.ie

5. Your feelings about my health

Using the faces  as a guide if person responds 'not very good' or 'awful' –please report to nurse/public health nurse/practice nurse/GP./house parent/team leader/social care worker/family member. Advocacy is also advisable. Advocacy services may support the person around health matters List of Advocacy Services available at: https://www.hse.ie/eng/about/qavd/complaints/ysysguidance/appendices/advocacy%20services.docx Local Advocacy groups may also be available.

6. My Body

Please list results if any, of measures outside the normal range. This will help us know what to do next.

Irrespective of height, a waist measurement of greater than 37 inches (94cm) for men or 32 inches (80cm) for women is an indicator of increased health risk.
(SAFEFOOD.EU)
Stop the Spread campaign.
https://www.icgp.ie/go/library/catalogue/item/DF2B8347-BCBE-4C31-94546BC305B29780

As per the MUST tool if a patient/person is low risk with MUST 0, monthly weights is recommended, if person is a MUST 1 medium risk, fortnightly weight checks are recommended and MUST 2 High risk then weekly weights is recommended.

Generally the more severe the intellectual disability the more risk of malnutrition due to swallowing concerns/dysphagia/posture/medical conditions/dementia etc.

The people with moderate intellectual disabilities or the more high functioning individuals tend to be at higher risk of becoming overweight/obese. Again weight checks are necessary here to monitor their weights and referral to a Dietitian/GP for support with a weight loss/healthy eating plan is needed.
https://www.hse.ie/eng/staff/pcrs/online-services/musttool.pdf

7. Your Medicines

HIQA Standard re: medicines
Multidisciplinary Annual Review should include a review of their medications.

The interval between full medication reviews should be no more than one year (NICE, 2014; HIQA 2015) and many persons will need more frequent medication reviews.

Refer to local policy for medication reviews

If not on medication –please indicate same –DO NOT LEAVE BLANK

8. Your Allergy History

This section to be completed in full –any allergy to be brought to the attention of nurse/public

health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.
If allergic to any medication –needs to be highlighted on medication prescription and administration record, risk assessment, hospital passport and support plan must be in place.

Ensure allergies are highlighted according to service policy

9. Your hair,nails and skin

Hair
If answer 'yes' please refer to nurse/public health nurse/practice nurse/GP. /house parent/team leader/social care worker/family member.

Nails
If answer 'yes' please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Skin
If answer yes to any of questions please refer to nurse/public health nurse/practice nurse/GP. /house parent/team leader/social care worker/family member.

10. Your eyes, ears mouth, nose and throat

Your eyesight
Any questions answered in the negative please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Your ears and my hearing
Any questions answered in the negative please refer to nurse/public health nurse/practice nurse/ house parent/team leader/social care worker/family member /GP.
Note:
Every 3 years for persons with Down Syndrome (WHO)
Person with Hearing aids may require more frequent hearing test.
https://www.hse.ie/eng/services/list/4/audiology/community-audiology/

Your mouth teeth and gums
If your mouth teeth and gums have not been checked in the past 12 months please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Recommendation:

Annual check-up with Dentist
Dental Hygienist every 6 months

Arising from vulnerable people's difficulties in accessing oral healthcare services, a variety of different approaches aimed at enabling them to avail of oral healthcare services have to be offered. These include clinical care pathways (for referral from primary care to supporting dedicated oral healthcare services) and pathfinder surveys for people in residential settings. The latter approach is a key component of oral health assessment for vulnerable groups and is necessary, as are individual oral health evaluation (clinical surveillance) assessments.
https://health.gov.ie/wp-content/uploads/2019/04/NOHP-Main-FINAL.pdf
(2019)

Your nose
If any responses are 'yes' please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Your throat
If any responses are 'yes' please refer to nurse/public health nurse/practice nurse/GP./house parent/team leader/social care worker/family member

11. Your mental and emotional health

 Using the faces as a guide on the health check assessment –if response is 'Ok' 'not very good' or 'awful', please refer to nurse/public health nurse/practice nurse/GP. /house parent/team leader/social care worker/family member.

Insert NICE guidelines here

Sleeping pattern record may be considered

12. Pain

If response indicates some level of pain please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Pain assessment tools available at:
http://hospicefoundation.ie/wp-content/uploads/2016/11/Final-Guidance-Document-5-Pain.pdf

13. Your memory

If responses indicate memory loss please refer to nurse/public health nurse/practice nurse/GP.
Recommendation:
Indications for doing a baseline screening dementia assessment:

- If the person is over 35 and has Down syndrome
- If the person is aged 50 years or over and has intellectual disability or other aetiology or has experienced changes in the last 6 months a baseline assessment is required.

14. Epilepsy

Complete section in its entirety if respondent has a diagnosis of epilepsy.

If no epilepsy skip this section.

Please note:
If respondent has been seizure free for past 2 years –medication review by Neurology Department

15. Your breathing and circulation

Your breathing
If response is 'yes to any of questions please refer to nurse/public health nurse/practice nurse/GP.

If no Blood Pressure records available –BP needs to be taken.

Vaccinations for influenza and pneumococcus are up to date

Be aware of at risk factors such as past history of aspiration and chest infections (Taggart,2014)

Your circulation
If response is 'yes' to any of questions please refer to nurse/public health nurse/practice nurse/GP. /house parent/team leader/social care worker/family member.
Recommendation;

Any person with an intellectual disability and over 40 years who is assessed to be at high risk of Cardio Vascular Disease should be offered a Cardiovascular risk assessment or health check. This will include;
Measurement of height weight and blood pressure
Cholesterol and sugar blood profile
Family history, medication ,diet and levels of physical activity (Taggart,2014)

16.Your digestion

If response is 'yes' to any of questions please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.
Higher incidence of Gastro Oesophageal Reflux Disease (GORD) in persons with ID

https://www.hse.ie/eng/health/az/a/acid-reflux/symptoms-of-gastro-oesophageal-reflux-disease.html

17.Your female health

If responses to questions raise concern for the assessor please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.

Register for BreastCheck- 50-69 years
Register for Cervical Check- 25-60 years
Register for Bowel check-60-69years
Register for Diabetic Retinal Screening (must have a diagnosis of Diabetes)
www.screeningservice.ie

18. Your male health

If responses to questions raise concern for the assessor please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.
Register for Bowel Check-60-69 years
Register for Diabetic Retinal Screening (must have a diagnosis of Diabetes)
General advice on Prostatic symptoms –discretion of GP.
www.screeningservice.ie

19. Your urinary health

If response is 'yes' to any of questions please refer to nurse/public health nurse/practice nurse/GP./ house parent/team leader/social care worker/family member.
Consider a baseline continence assessment if appropriate.
Sample assessment available from HSE website at:
https://www.google.com/search?q=continence+assessment+form+hse&oq=continence+assessment+&aqs=chrome.2.69i57j0j69i59j0l3.6387j0j4&sourceid=chrome&ie=UTF-8

20. Your mobility

If response is 'yes' to any of questions please refer to nurse/public health nurse/practice nurse/GP/house parent/team leader/social care worker/family member.

Consider a mobility assessment if appropriate
Assessments available at
https://www.hse.ie/eng/staff/safetywellbeing/healthsafetyand%20wellbeing/manualhandlingandpeoplehandlingpolicy.pdf

Bone Density assessment (DXA)
https://www.hse.ie/eng/health/az/b/bone-densitometry-scan/

For persons with Downs syndrome
If a person with Down syndrome develops any of the Red Flags/Warning Signs below:
Red Flags/Warning Signs:
- Neck pain, or pain behind the ear
- Abnormal head posture
- Torticollis(Wry neck)
- Reduced active neck movements
- Deterioration of gait and/or frequent falls
- Increasing fatigability on walking
- Deterioration of manipulative skills
- Loss of bowel and/or bladder function

https://downsyndrome.ie/wp-content/uploads/2018/05/Cervical-Spine-Disorders-Combined.pdf

21. Your bones and joints

Risk Factors will determine requirement for bone density testing
- Loss in height 2-16cm.

It is not normal at any age to suddenly loose height. Height loss of >2 inches is an important sign of an asymptomatic vertebral fracture and such persons should be evaluated for osteoporosis. A person can lose height due to wear and tear of vertebrae and/or disc but >2 inches is unusual in degenerative joint and disc disease. (ICGP,20111)
if you are taking any of the following :

- Anti – epileptic medicines
- Medicines for your mental health
- Medicines for your stomach

Consult your GP

22. Your feet

Consider Brunswick foot assessment if appropriate
https://www.gnb.ca/0053/phc/pdf/2015/10078e.pdf

Foot care and chiropody services check:
https://www.hse.ie/eng/services/list/4/olderpeople/tipsforhealthyliving/footcare.html

Resources

General

http://www.intellectualdisability.info/

www.easyhealth.org.uk

www.inclusionireland.ie

https://idstilda.tcd.ie/

https://www.health.nsw.gov.au/disability/Publications/being-a-healthy-woman-69-73.pdf

http://www.speakup.org.uk/?page_id=1412

Breastcheck

https://www.breastcheck.ie/content/news/breastcheck_develops_manual_for_women_with_intellectual_disabilities

http://www.easyhealth.org.uk/sites/default/files/My%20boobs%20and%20me.pdf

Cervicalcheck

https://www.cervicalcheck.ie/_fileupload/File/Guide%20for%20Smeartakers_Jan_09/Chapter%206%20Womens%20Participation.pdf