Service User ID label :

SIX MONTHLY PHYSICAL HEALTH ASSESSMENT

DATE_____

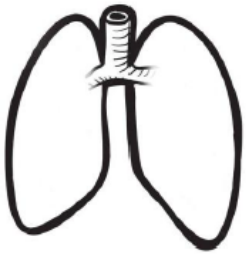
PHYSICAL OBSERVATIONS (To be completed by doctor or nurse):

Height: _____m **Blood Pressure:** _____ **Resp. Rate:** _____resp/min
Weight: _____kg **Heart Rate:** _____bpm **Blood Sugar** *(if relevant)* _____
BMI: _____ **Temperature:** _____°C **Urinalysis:** _____
Waist: _____cm **Oxygen Saturation:** _____% **HCG:** _____
Name (Print): _____ **Signed:** _____
Discipline: _____ **Professional Register No:** _____ **Date:** _____

THIS SECTION TO BE COMPLETED BY TREATING DOCTOR: PHYSICAL EXAMINATION
(Can also be completed by appropriately trained Advanced Nurse Practitioner (ANP))

Consent: ☐ Service user declined. Allergies: _____
☐ Verbal consent obtained.
Chaperone: ☐ Chaperone used (same gender as service user)

RESPIRATORY:
(tick all that apply)



☐ Chest Clear
☐ Equal Air Entry
☐ No Wheeze
☐ No crepitations
☐ Other:
_____

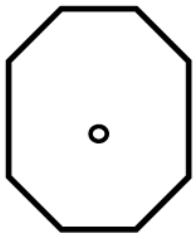
CARDIOVASCULAR:
(tick all that apply)

☐ Warm & Peripherally well perfused
☐ Normal Sinus Rhythm
☐ Normal Heart Sounds
☐ Other:
_____
_____

ECG:
(tick all that apply)

☐ Declined / Unable to Answer
☐ Not needed
☐ Ordered
☐ Done. Results:

ABDOMEN:
(tick all that apply)



☐ Soft, non-tender
☐ No guarding
☐ No organomegaly
☐ Normal bowel sounds
☐ Other:
_____
_____

NEUROLOGICAL:
(tick all that apply)

☐ Cranial Nerves Intact
☐ Power 5/5 throughout upper & lower limbs
☐ Normal reflexes
☐ Normal sensation
☐ Not formally assessed
☐ Other/Comments: _____

GENERAL/OTHER CONSIDERATIONS:
(tick all that apply)

Anaemia ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Cyanosis ☐ Yes ☐ No
Oedema ☐ Yes ☐ No
Thyroid exam ☐ Yes ☐ No
Gynecomastia ☐ Yes ☐ No
Needs prophylaxis for Venous Thrombosis ☐ Yes ☐ No
Calves - Evidence of DVT ☐ Yes ☐ No

Comments: Other physical health issues identified please list

_____
_____
_____
_____

Service User ID label :

PHLEBOTOMY: (tick all that apply)

☐ Declined ☐ Unable to Answer ☐ Bloods ordered

Samples taken

☐ FBC	☐ Lipid Profile	☐ HBA1C
☐ U&E's	☐ Fasting Glucose	☐ Prolactin
☐ CRP	☐ B12	☐ Others:
☐ LFT's	☐ Folate	
☐ TFT's	☐ Vit D	

Update on Family or Relevant Medical History since admission: _____

_____

_____

How would you describe your physical health? _____

_____

_____

Do you wish to tell me about any physical problems including any pain you may be experiencing? _____

_____

_____

_____

Has there been any changes or concerns since last Physical Health Assessment in relation to:

☐ Weight ☐ Change to your appetite ☐ Swallowing ☐ Feeling of choking on food and drinks

☐ Coughing during or after a meal ☐ Problems chewing food ☐ A number of recent chest infections

Details: _____

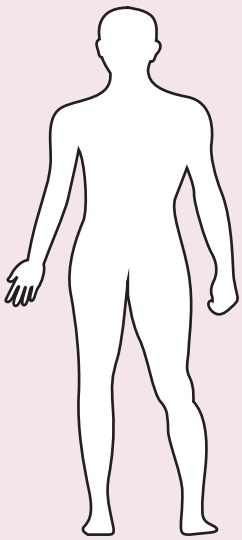
_____

(If required please indicate referral to Dietitian and/or Speech & Language Therapist (SLT) team as available)

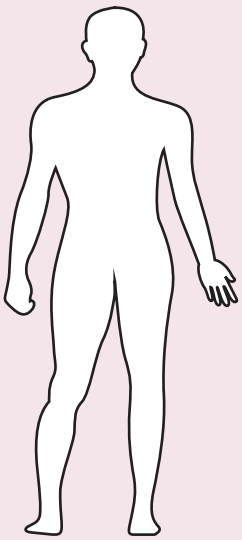
☐ Service User Declined to answer ☐ Service user unable to answer box ☐ Not clinically appropriate at this time

Please mark on diagram any abnormalities, areas of bruising, skin cyanosis, skin condition including pressure sores, wounds, rashes, puncture marks, and self harm, OR please tick (√) if no abnormalities detected ☐

FRONT



BACK



General Appearance:

_____

_____

_____

_____

_____

_____

_____

_____

Name of Doctor/ANP (Print):

_____

Signed: _____

MCRN No: _____

Date: _____

Service User ID label :

LIFESTYLE ASSESSMENT

The following section is to be completed by any member of the Treating Multidisciplinary Team.

All relevant information from this Physical Health Assessment form to be included in the service users Individual Care Plan (ICP)

National Screening Programme

National Screening Programme (NSP) as per eligibility criteria. *(Please circulate eligible programmes)*

Bowel Screen (adults aged 60-69yrs) **Breast Check** (women aged 50-69 yrs)

Cervical Check (women aged 25-60 yrs) **Diabetic Retinal Screening** (Type 1 & Type 2 diabetics 12yrs and over)

Has service user attended relevant screening programmes? ☐ Yes ☐ No _____

GIVEN brief advice / brief intervention on screening programmes and made aware of the **Free-phone 1800 454 555** to check if they are on the relevant Screening Programmes' register? ☐ Yes ☐ No

GP/Dental/Optical Assessment

General Practitioner Contact: *Please Circle* Regular Infrequent Rarely

Dental Practitioner Contact: *Please Circle* Regular Infrequent Rarely

Does service user have any dental problem? ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Dentures: Any issues with dentures ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Obvious caries: Advice given re dental care ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Painful teeth/Gums: ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Referred to Dentist: ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Does service user have any problems with eyesight? ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Glasses: Any issues with glasses ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Referred to Opticians: ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Does service user have any problems with hearing? ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Hearing aid : Any issues with hearing aids ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Referred to Audiologist: ☐ Yes ☐ No ☐ Declined ☐ Unable to Answer

Medication Review

Is service user on medication? ☐ Yes ☐ No

Has the medication been reviewed? ☐ Yes ☐ No

SLEEP

Does service user have any problems with sleep? ☐ Yes ☐ No ☐ Not Asked ☐ Declined / Unable to Answer

How many hours did Service User sleep last night? _____

How many hours does Service User usually sleep at night? _____

Does Service User take sleeping tablets? ☐ Yes ☐ No If yes please give name/dosage _____

GIVEN brief advice / brief intervention on sleep hygiene ☐

Date:_____/_____/_____ **Signature:** _____ **Discipline:** _____

TOBACCO USE

1. Does service user SMOKE any tobacco products?

- Daily ☐
- Occasional (Less than daily) ☐
- Quit Smoking (within last 6 months) ☐
- Quit Smoking (longer than 6 months) ☐
- Never ☐
- Service user declined/not interested at this time ☐
- Service user capacity or decision making diminished ☐
- Family member/carer involved ☐

TOBACCO INTERVENTION

If service users does not smoke or has quit longer than 6 months affirm and reinforce benefits of being tobacco free ☐

If service user is a Tobacco User (daily or occasional smoking) or has QUIT WITHIN THE LAST 6 MONTHS tick all actions taken Brief intervention

(emphasising the benefits of quitting and offering strategies to help quit)

Signposted to HSE Tobacco cessation services /QUIT service (helpline 1800 201 203 and www.quit.ie) ☐

Referred to HSE Tobacco cessation services /QUIT services Prescribed/

Referred for Stop Smoking medication (NRT/Varenicline) ☐

Service user declined/not interested in quitting at this time ☐

Date:_____/_____/_____ **Signature:** _____ **Discipline:** _____

ALCOHOL USE (AUDIT-C TOOL)

	Score
1. How OFTEN do you have a drink containing alcohol?	
Never	0
Monthly or less	1
2-4 times a month	2
2-3 times a week	3
4 or more times a week	4
2. How MANY standard drinks (10 grams) of alcohol do you have on a typical day when drinking?	
1-2	0
3-4	1
5-6	2
7-9	3
10 or more	4
3. How OFTEN do you have 6 or more standard drinks (10 grams each) on a single occasion in the last year?	
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

ALCOHOL SCORE _____
(Add scores from all three questions)

ALCOHOL RISK

Total SCORE 0-4 **LOW RISK** ☐

Total SCORE 5+ **INCREASED RISK** ☐

ALCOHOL INTERVENTION

If service user is assessed as Low Risk 0-4: AFFIRM and reinforce benefits of remaining at the low risk level. ☐

If service user is assessed as **Increased Risk 5+:**

Engage service user in a brief intervention to discuss the following:

The risks to health of drinking in short and long term ☐

The benefits of cutting down ☐

Strategies for managing drinking pattern ☐

(To assist with this discussion you can refer to "A Quick Question" leaflet https://www.healthpromotion.ie/A_Quick_Question)

Signpost to www.askaboutalcohol.ie ☐

Refer to HSE Drug and Alcohol Helpline Mon-Fri 9.30-5.30 Tel.1800 459 459 for information on local alcohol and drug services ☐

RECOMMEND that service user discuss with GP/Doctor/MDT ☐

Refer to specialist substance misuse service ☐

Service user declined/not interested at this time ☐

Service user capacity or decision making diminished ☐

Family member/carer involved ☐

LOW RISK GUIDELINES

- 11 standard risk or less for Women with two alcohol free days
- 17 standard drinks for Men with two alcohol free days

For men and women avoiding any alcohol on at least 2-3 days/week is important

Date:_____/_____/_____ **Signature:** _____ **Discipline:** _____

BODY WEIGHT

If any of the following are present refer to GP / MDT / Dietetics / SLT as appropriate

(Brief Intervention not indicated at this time)

- Unplanned weight change in past 3-6 months
- Taking oral nutritional sup plement product
- Swallowing problems
- Unable to eat or drink
- Self induced vomiting/ bingeing/ taking non prescription diet pills/laxatives

Focus of Brief Intervention is healthy eating and limiting weight gain. BMI measurement (where feasible) is included to promote the routine measurement of BMI in practice.

1. BMI status

Height in metres _____

Weight in Kilos _____

BMI _____

Waist Circumference: _____

2. BMI Categories

Underweight BMI < 18.5 ☐

Healthy weight BMI 18.5- 24.9 ☐

Overweight BMI 25 - 29.9 ☐

Obese BMI >30 ☐

BMI not done/Not appropriate at this time ☐

Service user declined/not interested ☐

NUTRITION INTERVENTION

BMI < 18.5 UNDERWEIGHT

Referred to GP/MDT /dietetic services for nutritional screening ☐

BMI 18.5 – 24.9 HEALTHY WEIGHT

Brief intervention (Emphasising benefits of and strategies to maintain healthy weight) ☐

Signposted to www.hse.ie/healthyeatingactiveliving.ie; Healthy Food for Life Booklet ☐

Service user declined/not interested ☐

Service user capacity or decision making diminished ☐

Family member/carer involved ☐

BMI 25 - 30 OVERWEIGHT

Brief intervention (Emphasising the benefits of healthy eating, increasing fruit & vegetable intake, strategies to prevent weight gain) ☐

Signposted to relevant resources/local weight management services (HSE or Private) www.hse.ie/selfmanagementsupport ☐

Referred to dietetic services if 2 or more co morbidities exist ☐

Service user declined/not interested ☐

Service user capacity or decision making diminished ☐

Family member/carer involved ☐

BMI > 30 OBESE

Brief intervention (Emphasising the benefits of healthy eating, increasing fruit & vegetable intake, strategies to prevent weight gain) ☐

Signposted to relevant resources/local weight management services (HSE or Private) www.hse.ie/selfmanagementsupport Referred to dietetic services ☐

Service user declined/not interested ☐

Service user capacity or decision making diminished ☐

Family member/carer involved ☐

Date:_____/_____/_____ **Signature:** _____ **Discipline:** _____

PHYSICAL ACTIVITY

1. In a typical week, how many days has the service user been physically active (PA) for total of 30 minutes or more?

(may not be suitable for those with eating disorders)

0 days (Inadequate) ☐

1 - 4 days * ☐

5 - 7 days (Adequate) ☐

Unable to be physically active ☐

No information available ☐

* **IF SERVICE USER STATES 1-4 DAYS, ask if they engage in 150 minutes moderate activity or 75 minutes vigorous activity in a typical week?**

Yes (Adequate) ☐

No (Inadequate) ☐

No information available ☐

PHYSICAL ACTIVITY INTERVENTION

SERVICE USERS REPORTING INADEQUATE ACTIVITY

(tick all actions taken)

Brief intervention on benefits of physical activity ☐

Signposted to national websites www.getirelandactive.ie and www.lets-get-active-guidelines.pdf for support ☐

Service user declined/not interested ☐

Service user capacity or decision making diminished ☐

Family member/carer involved ☐

Physical Activity Guidelines for adults is at least 30 minutes of moderate intensity activity 5 days per week

Physical activity may include: walking/cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes

Physical Health 6 Monthly Assessment Next Due On - Date: _____/_____/_____

Name (Print): _____ **Signed:** _____

Professional Register No: _____ **Date:** _____/_____/_____