Medicare Health Assessment for people with an intellectual disability

Proforma

Use of a specific form to record the results of the health assessment is **not** mandatory but the health assessment should cover the matters listed below. The first two pages of this form can be used as a report of the health assessment.

This proforma must be read in conjunction with the explanatory notes for **MBS Items 701, 703, 705 and 707**.

**Patient details**
Name ........................................................................................................................................
Address ....................................................................................................................................
Phone .......................................................................................................................................
Date of birth ........../....../..... Male / Female

**Carer details**
Name ........................................................................................................................................
Address ....................................................................................................................................
Phone .......................................................................................................................................

**Consent**
Explanation of health assessment given to patient and/or carer
Patient consent for health assessment given on ....../....../.....
Patient consent for information to be collected by nurse
Other health professional .....................

**Previous health check**
Has the patient had a previous health assessment Yes / No
Date of last health assessment ....../....../.....
Service provided by Dr .............................

Patient’s overall health status
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Health issues identified and discussed with patient and/or carer
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
**Tests undertaken, results and what they mean (some results may not be available)**

Note: The assessment should not include diagnostic or pathology services unless the health assessment detects issues that require clinically relevant diagnostic imaging or pathology services.

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<tr>
<th>Test</th>
<th>Available results</th>
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**Recommended intervention action**

- ...
- ...
- ...
- ...
- ...

**Action to be taken by patient and/or carer**

- ...
- ...
- ...
- ...
- ...

Next appointment with doctor  

Next health assessment  

Name of GP  

Signature  

Date  

....../..../....

....../..../....
Patient history

Paediatrician

Government provided or funded disability service

Previous presentations

Family relationships

Care arrangements

Current problems

Current risk factors

Allergies/drug intolerance
Health assessment as relevant to the patient:

*Check dental health (including dentition)*

Identified issues

__________________________________________________________________________

Action

__________________________________________________________________________

*Conduct aural examination (arrange formal audiometry every 5 years)*

Identified issues

__________________________________________________________________________

Action

__________________________________________________________________________

*Assess ocular health (arrange ophthalmologist/optometrist review every 5 years)*

Identified issues

__________________________________________________________________________

Action

__________________________________________________________________________

*Assess nutritional status and review growth and development*

Weight ........................................... Height ...........................................

Identified issues

__________________________________________________________________________

Action

__________________________________________________________________________

*Assess bowel and bladder function (particularly for incontinence and chronic constipation)*

Identified issues

__________________________________________________________________________

Action

__________________________________________________________________________
Assess medications (including ‘non-prescription’ medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications)

Identified issues

Action

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Check immunisation status (refer to the current Australian Standard Vaccination Schedule (NHMRC) for appropriate vaccination schedules)

- Influenza
- Tetanus
- Hepatitis A
- Hepatitis B
- Measles
- Mumps
- Rubella (MMR)
- Pneumococcal

Identified issues

Action

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Check exercise opportunities (aim for at least 30 minutes of moderate exercise per day)

Identified issues

Action

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Check and review support provided for activities of daily living

Identified issues

Action
Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment

Identified issues

Action

Check for dysphagia and gastro-oesophageal disease, especially for patients with cerebral palsy, and arrange investigation/treatment as required

Identified issues

Action

Assess risk factors for osteoporosis and arrange investigation/treatment as required

Identified issues

Action

For patients diagnosed with epilepsy, review seizure control (including anticonvulsant drugs) and refer to neurologist as appropriate

Identified issues

Action

Screen for thyroid disease at least every two years (or yearly for patients with Down syndrome)

Identified issues

Action
For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years

Identified issues

Action

Assess or review treatment for comorbid mental health issues

Identified issues

Action

Consider timing of puberty and management of sexual development, sexual activity and reproductive health

Identified issues

Action

Consider any signs of physical, psychological or sexual abuse

Identified issues

Action

Health assessment as relevant to the patient
The balance between the patient’s health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should also consider the following:

Medical
- Consider follow-up consultations where medical treatment is required (e.g. high blood pressure, likelihood or other health problems)
- Assess pathology if continence problems are evident

Action
**Physical function**
- Consider the health impact of the patient’s general skills levels and daily activities
- Consider the need for a referral for a formal review of activities of daily living

**Psychological function**
- Consider and investigate medical/psychiatric causes where problems with cognition and skill decline are clinically suspected
- Consider depression where there is change in weight, sleep habit and escalation of behavioural problems
- Ensure there are systems in place to keep track of the patient’s current behavioural status
- Consider psychiatric disorders when changes in behaviour are evident

**Social function**
- Assess suitability of the patient’s accommodation setting to provide the best physical and psychological outcomes
- Consider issues that relate to the care provided by the patient’s carer to meet the health related needs of the patient

**Other examinations as considered necessary by the GP**

**Involving the patient’s carer or appropriate disability professionals**
- Consider the need for referrals such as accommodation, daily assistance assessment, disability support services and psychologists