Family Health Information Recording System (FAMILY-HIRS)

Designed by:

PCHC

A Core Program of

PHCC

PHILADELPHIA COORDINATED HEALTH CARE

123 South Broad Street
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Funding provided by Philadelphia Department of Behavioral Health/ Intellectual disAbility Services, the Bucks, Chester, Delaware and Montgomery County Offices of Intellectual/Developmental Disabilities and the Office of Developmental Programs, Pennsylvania Department of Public Welfare

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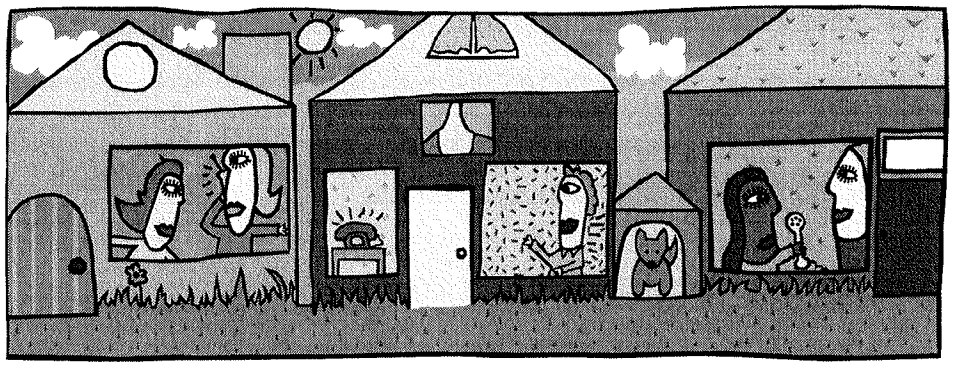

A medical record keeping system designed to meet the needs of families, individuals, caregivers and health care professionals...

Philadelphia Coordinated Health Care

Mission Statement

Philadelphia Coordinated Health Care's mission is to enhance access to community physical and mental health care through education, public health outreach, advocacy and empowerment as well as to improve health care outcomes for individuals with intellectual and developmental disabilities.

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Section 1

PERSONAL INFORMATION

Name		Phone
Address		County
Date of Birth	Age	SSN

Allergies/ Sensitivities

Does the person have any allergies? ☐ Yes ☐ No ☐ Unsure

What causes the problem (dust, penicillin, etc.)?	What happens (sneezing, rash, etc.)?

INSURANCE

If this person has any other health insurance and Medical Assistance/Medicaid coverage, the person's Medicaid HMO will be the last insurance billed for health care. The order of billing is as follows:

1. Private/commercial insurance
2. Medicare insurance
3. Medical Assistance/ Medicaid insurance.

Providers of health services will bill all insurers to obtain the maximum allowable amount for the service provided.

Medicaid Information

PA Medicaid/Access Number:	Medicaid HMO Phone Number (if applicable):
Indicate if the person has: ☐Americhoice ☐Keystone HMO ☐ HealthPartners ☐ Straight MA Fee-for-Service I.D. Number: _____	

Medicare Prescription Drug Plan (if applicable)

Name:	Policy Number:

Medicare (if applicable)

Policy Number: _____

☐Plan A ☐Plan B ☐Both

Medicare HMO

Name: _____ Number: _____

Private/ Commercial/ Other Insurance (if applicable)

Type of Insurance (general health, dental, vision, mental health, etc)

_____

Who's name is the insurance under?

_____

Insurance Policy Number:

_____

Type of Insurance (general health, dental, vision, mental health, etc)

_____

Who's name is the insurance under?

_____

Insurance Policy Number:

_____

ID SUPPORTS

Is this person registered for services with the MH/IDS County Office? Yes No

Is this office in the County in which the person resides? Yes No

If not, which County are they registered for services in: _____

Supports Coordinator (if applicable)

Name	Agency/ Office
Address	BSU #
How to contact:	

Agency Supports (residential, day, etc.)

Agency Name	Service Agency Provides
Address	
Agency Phone Number	
Contact Person at Agency	
Best Way to Reach Contact Person	

Agency Name	Service Agency Provides
Address	
Agency Phone Number	
Contact Person at Agency	
Best Way to Reach Contact Person	

FAMILY HEALTH HISTORY

Why It Is Important

An accurate family medical history can have a positive impact on a person's health. Health care providers need complete information to provide comprehensive healthcare.

Family Member	Name	D.O.B.	Living?	If deceased, at what age?	If known, give cause of death
Mother					
Maternal Grandmother					
Maternal Grandfather					
Father					
Paternal Grandmother					
Paternal Grandfather					
Sibling M/F					
Sibling M/F					
Sibling M/F					
Sibling M/F					

FAMILY HEALTH HISTORY con't

Check all that apply. If "other" applies, list the disease or condition to which you are referring.

Disease/ Condition	Mother	Maternal Grand-mother	Maternal Grand-father	Father	Paternal Grand-mother	Paternal Grand-father	Sibling (Indicate Sibling's Name)
Cancer							
TB							
Heart Disease							
Stroke							
High Blood Pressure							
High Cholesterol							
Lung Problems							
Stomach Problems							
Thyroid Problems							
Diabetes							
Kidney Disease							
Sickle Cell Disease							
Anemia							
Migraine Headaches							
Epilepsy							
Arthritis							
Deafness							
Cataracts							
Glaucoma							
Depression							
Bipolar Disorder							
Schizophrenia							
Intellectual Disability							
Autism							
Anxiety Disorder(s)							
Other							
Other							
Other							

HEALTH CARE DECISION MAKING

Is the person able to make his/her own healthcare decisions? ☐ Yes ☐ No ☐With Assistance	
If not, who is the person who makes healthcare decisions? Name Relationship	
Address	
Home Phone Number	Work Phone Number
Best Way to Contact	
Does this person have a (court appointed) legal guardian? ☐Yes ☐ No	
If so, who is that person?	
Name	Relationship
Address	
Home Phone Number	Work Phone Number
Cell Phone/Pager Number	Best Way to Contact

Emergency Contact

Name	Relationship
Address	
Home Phone Number	Work Phone Number
Cell Phone/ Pager Number	Best Way to Contact

Family HIRS

Section 2

DOCTOR and PHARMACY INFORMATION

Primary Health Care

Primary Care Provider	Phone
Address	

Preferred Hospital

Hospital Name	Phone
Address	

Medical Specialists

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

DOCTOR and PHARMACY INFORMATION con't

Pharmacy

Name	Specialty
Address	
Phone Number	Fax Number

Name	Specialty
Address	
Phone Number	Fax Number

Dentist (see Health Treatment Supports Form section 3)

Name	Specialty
Address	
Phone Number	Fax Number

OTHER HEALTH PROVIDERS

Durable Medical Equipment Company

Name	
Address	
Phone Number	Fax Number

Transportation Company Used

Name	
Address	
Phone Number	Fax Number

Secondary Transportation Company

Name	
Address	
Phone Number	Fax Number

Ambulance Company

Name	
Address	
Phone Number	Fax Number

Family HIRS

Section 3

HEALTH TREATMENT SUPPORTS

Is there anything that is helpful with health exams/ treatments? (i.e. Mother goes with individual on medical appointments)

Are there any health exams/treatments for which sedation is needed? ☐**Yes** ☐**No**

If yes, list practitioner(s), frequency, type of sedation and name of the medication given below:

Name of Health Practitioner Seen	Frequency	Medication Given	
		Type of Sedation	Name of Medication
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	
	☐ Always ☐ Sometimes ☐ Never	☐ By Mouth ☐ Conscious Sedation ☐ General Anesthesia	

Has this person experienced any adverse effects from sedation/ anesthesia ? ☐**Yes** ☐**No**
If yes, explain:

ANNUAL PHYSICAL EXAMINATION FORM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ SSN: _____

_____ Date of Birth: _____

Sex: ☐Male ☐Female Name of Accompanying Person: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS: *(Include a Medical History Summary and Chronic Health Problems List, if available)*

CURRENT MEDICATIONS: *(Attach a second page if needed)*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Does the person take medications independently? ☐Yes ☐No

Allergies/Sensitivities: _____

Contraindicated Medication: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years)*: ____/____/____ **Type administered:** _____

Hepatitis B: **#1** ____/____/____ **#2** ____/____/____ **#3** ____/____/____

Influenza (Flu): ____/____/____

Pneumovax: ____/____/____

Other: *(specify)* _____

TUBERCULOSIS (TB) SCREENING: *(every 2 years by Mantoux method; if positive initial chest x-ray should be done)*

Date given _____ **Date read** _____ **Results** _____

Chest x-ray (date) _____ **Results** _____

Is the person free of communicable diseases? ☐**Yes** ☐**No** *(If no, list specific precautions to prevent the spread of disease to others)*

_____

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: *(women over age 18)* **Date** _____ **Results** _____

Mammogram: *(every 2 years- women ages 40-49, yearly for women 50 and over)* **Date:** _____ **Results:** _____

Prostate Exam: *(digital method-males 40 and over)* **Date:** _____ **Results:** _____

Hemoccult **Date:** _____ **Results:** _____

Urinalysis **Date:** _____ **Results:** _____

CBC/Differential **Date:** _____ **Results:** _____

Hepatitis B Screening **Date:** _____ **Results:** _____

PSA **Date:** _____ **Results:** _____

Other *(specify)* _____ **Date:** _____ **Results:** _____

Other *(specify)* _____ **Date:** _____ **Results:** _____

HOSPITALIZATIONS/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

Part Two: GENERAL PHYSICAL EXAMINATION

Please complete all information to avoid return visits.

Blood Pressure:_____/_____ Pulse:_____ Respirations:_____ Temp:_____ Height:_____ Weight:_____

EVALUATION OF SYSTEMS

System Name	Normal Findings?	Comments/Description
Eyes	☐Yes ☐No	
Ears	☐Yes ☐No	
Nose	☐Yes ☐No	
Mouth/Throat	☐Yes ☐No	
Head/Face/Neck	☐Yes ☐No	
Breasts	☐Yes ☐No	
Lungs	☐Yes ☐No	
Cardiovascular	☐Yes ☐No	
Extremities	☐Yes ☐No	
Abdomen	☐Yes ☐No	
Gastrointestinal	☐Yes ☐No	
Musculoskeletal	☐Yes ☐No	
Integumentary	☐Yes ☐No	
Renal/Urinary	☐Yes ☐No	
Reproductive	☐Yes ☐No	
Lymphatic	☐Yes ☐No	
Endocrine	☐Yes ☐No	
Nervous System	☐Yes ☐No	
VISION SCREENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No
HEARING SCREENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No

Additional Comments:

Medical history summary reviewed? ☐Yes ☐No

Medication added, changed, or deleted: *(from this appointment)*_____

Special medication considerations or side effects: _____

Recommendations for health maintenance: *(include need for lab work at regular intervals, treatments, therapies, exercise, hygiene, weight control, etc.)*

_____

Recommendations for manual breast exam or manual testicular exam: *(include who will perform and frequency)*_____

_____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency:

_____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)*: ☐No ☐Yes *(specify)*

_____

Does this person use adaptive equipment? ☐No ☐Yes *(specify)*:_____

Change in health status from previous year? ☐No ☐Yes *(specify)*:_____

This individual is recommended for ICF/MR level of care? *(see attached explanation)* ☐Yes ☐No

Specialty consults recommended? ☐No ☐Yes *(specify)*:_____

Seizure Disorder present? ☐No ☐Yes *(specify type)*:_____ **Date of Last Seizure:** _____

_____ _____ _____

Name of Physician *(please print)* Physician's Signature Date

Physician Address: _____ Physician Phone Number: _____

IMMUNIZATIONS

This list is only a general grouping. If other immunizations have been administered, please list them in the "other" section.

Immunization	Date Given	Date Given	Date Given	Date Given
DTP (Dypthaeria Tetanus Pertussis)				
Td (Tetanus)				
IPV (Polio)				
MMR (Measels Mumps Rubella)				
Hepatitis B Series				
Lymerix (Lymes)				
PPD /Mantoux (Tuberculosis)				
PCV Pneumovax (Pneumonia)				
Flu Shot				
Varicella Varivax (Chicken Pox)				
Other				
Other				

HEALTH APPOINTMENT LOG

A CHRONIC health condition is a health condition that a person has for more than six months and is characterized by frequent reoccurrence.

An ACCUTE health condition is a health condition characterized by symptoms of short duration (ex.: common cold)

An example of a ONE-TIME visit would be a visit for a flu shot.

An example of a RESOLVED visit would be a follow up visit for an ear infection.

Date of Visit	Reason(s) for Visit	Health Provider Name and Specialty	Result	Chronic	Acute	One-Time	Re-solved	Follow-up Date
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	

Family HIRS

Section 4

CHRONIC HEALTH PROBLEMS

A CHRONIC health condition is a health condition that a person has fore more than six months and is characterized by frequent reoccurrence (for example, Mental Retardation).

You can contact your medical practitioner to learn the name of the diagnosis and axis.

Condition List

Date of Onset (if known)	**Psychiatric Disorders/Diagnosis** (ex: diagnosis of depression)
Date of Onset (if known)	**Intellectual Disability and Personality Disorders**

CHRONIC HEALTH PROBLEMS con't

Date of Onset (if known)	General Health Conditions	Health Care Provider Name and Specialty

MEDICATION LISTING LOG

Make a new entry when a medication is started, increased, decreased, or discontinued

Date	Medication	Dosage	Frequency	Diagnosis	Medication Status			Reason for Change (if applicable)	Prescribing Physician Name and Specialty
					In-crease	De-crease	Dis-Con-tinue		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		
					☐	☐	☐		

HOSPITALIZATIONS

Reason / Admitting Diagnosis	Date of Admission	Discharge Diagnosis	Date of Discharge

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART ONE: HEALTH SERVICES REPORT

(To be completed by agency/residential personnel, e.g. nurse, program specialist, family member, prior to psychotropic medication review.)

INDIVIDUAL:	**DATE-PSYCHOTROPIC MED REVIEW:**
ADDRESS:	**PREVIOUS REVIEW:**
DATE OF BIRTH: **BSU #:**	**PHYSICIAN'S NAME:**
AGENCY CONTACT:	**OFFICE ADDRESS:**
AGENCY PHONE #:	**OFFICE PHONE #:**

CURRENT MEDICATIONS *(Please list **all** medications--including OTC medications, dietary supplements, etc. **Attach additional pages if necessary. Include individual's name and date of review on every page.**)*

MEDICATION NAME	DOSAGE	FREQUENCY	*Reason for Administration*

ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? ☐No ☐Yes

*If "**Yes**", Specify and describe all symptoms:*

HAS THIS DIAGNOSIS CHANGED? SEE PAGE 3 and check if updated: ☐	**DIAGNOSIS** *(5-Axis Diagnosis from a physician, as documented in medical records)*	**TARGET SYMPTOMS** *(BEHAVIORAL DESCRIPTION)* ***Target Symptoms listed here must match those listed on Part 2***
AXIS I ***(MH Diagnosis)***		
AXIS I (2)		
AXIS II ***(ID Diagnois)***		
AXIS II ***(Personality Disorder)***		
AXIS III ***(All Medical Diagnoses)***		

Axis IV *(Psychosocial Stressors)*: as documented by physician/medical records. Notify physician if new issues/changes. **Check all that apply:**

☐ Problem with primary support group ☐ Problems with access to health care services ☐ Housing problems
☐ Problems related to the social environment ☐ Occupational problems ☐ Economic problems
☐ Educational problems ☐ Problems related to interaction with the legal system/crime ☐ Other psychosocial and environmental problems

Axis V *(Global Assessment of Functioning/GAF)* ***Score (0-100)*** _____ ***(Score provided by physician per DSM scale, updated annually)***

LAST TARDIVE DYSKINESIA SCREENING ***(e.g. AIMS test)***: *(Include date and result--**required every 6 months**)*

SCORE: _____ ***DATE:*** _____ ***N/A:*** _____

CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE *(Attach significant lab and diagnostic study results):*

CHECK all items that were an issue since the last psychotropic medication review. Add comments below whenever possible.

☐appetite + / - ☐constipation ☐dry mouth ☐nausea/vomiting ☐swelling ☐alcohol use
☐bruising ☐cough ☐incontinence ☐seizures ☐weight + / - ☐nicotine use
☐congestion ☐diarrhea ☐menstrual change ☐thirst ☐pain ☐caffeine use
☐other drug use

COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST: *(Please describe)*

Printed** name **and** signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report. **This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.

Completed by: *(Printed Name and Signature):*	**Title:**	**Date Signed:**
Agency Nurse Review: *(Printed Name & Signature):*	**Title:**	**Date Signed:**

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART TWO: BEHAVIOR SUPPORT TREATMENT REPORT

(To be completed by monitoring team member [behavior specialist, QMRP, program specialist, family member] prior to review.)

INDIVIDUAL:	**DATE OF PSYCHOTROPIC MED REVIEW:**

LEVEL OF RESTRICTIVENESS PER BEHAVIOR INTERVENTION POLICY**

☐ **LEVEL I** ☐ **LEVEL II** ☐ **LEVEL III** ☐ **NOT APPLICABLE (Not registered with Phila.)**

***This is only for individuals funded by Philadelphia County, see Philadelphia Behavior Intervention Policy for details*

TARGET SYMPTOMS BEING DOCUMENTED

*Include **BEHAVIORAL DESCRIPTIONS** of Target Symptoms for each mental health diagnosis listed on Axis I on Part 1 of this form. Behavioral descriptions must be **specific to the individual**. For each target symptom, **fill in the number of occurrences for the past 6 months.** Additional charts/graphs may be attached. **Add comments wherever possible.***

Target Symptoms (from Part 1) BEHAVIORAL DESCRIPTION (***MUST MATCH*** *those listed on Part 1*)	**Monthly Data (past 6 months)** Fill in month and frequency of each Target Symptom						**Comments**
1)							
2)							
3)							
4)							

ADDITIONAL CONCERNS SINCE LAST REVIEW

Check any symptoms or environmental changes *not being documented above* that have appeared since the last review (clarify in Additional Comments section below)

☐ Activity Level (increased or decreased)	☐ Obsessive-Compulsive Behavior	☐ Unusual Body Movements (e.g., tremors)
☐ Anxiety	☐ Sleep Changes	☐ Other (Specify):
☐ Appetite (increased or decreased)	☐ Suicidal ideation/behavior	☐ None
☐ Change in Mood	☐ Environmental Issues	☐ Psychotic Symptoms

ADDITIONAL COMMENTS

Signature(s) indicate that prior psychotropic medication review reports were reviewed in preparing this report. ***This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.***

SUMMARY COMPLETED BY:	Date form completed:
Name:	
Role:	Date reviewed with team:
Signature:	Date reviewed w/prescribing physician:

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART THREE: PHYSICIAN'S REPORT *(To be completed by physician prescribing psychotropic medication)*

INDIVIDUAL:

DATE OF PRESENT PSYCHOTROPIC MED REVIEW:	DATE OF NEXT PSYCHOTROPIC MED REVIEW:

PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS: **(see Page 1 and Page 2)**

Do the diagnosis(es) in Part 1 and the target symptoms in Part 2 remain as indicated on Part 1: *Health Services Report* and Part 2: *Behavior Support Treatment Report*? ☐ **Yes** ☐ **No** If **NO,** *please change to:*

TREATMENT GOALS (Regarding Target Symptoms listed on Parts 1 and 2):	**PROGRESS TOWARD GOALS:**

♦ Psychotropic medications are necessary?	☐Yes ☐No	
♦ Psychotropic medication dosages are within usual range?	☐Yes ☐No	
♦ Number of drugs conforms to accepted standards?	☐Yes ☐No	
♦ Are medication side-effects present? *(e.g. sedation, ataxia, dyscrasia)*	☐Yes ☐No	
♦ Screening test performed (e.g. AIMS)?	☐Yes ☐No	
♦ Symptoms of T.D. or other E.P.S.?	☐Yes ☐No	
♦ Medication reduction plan considered?	☐Yes ☐No	

PHYSICIAN'S ORDERS

MEDICATION CHANGE: ☐ **No** ☐ **Yes** ***(provide information below)***

NEW MEDICATION (List medication, dosage & frequency)			**REASON FOR NEW MEDICATION**
Medication	**dosage**	**frequency**	**Medication Education Provided?** ☐Yes ☐No
1)			
2)			
3)			

MEDICATION CHANGE (List med., dosage & frequency)			**REASON FOR MEDICATION CHANGE**
Medication	**dosage**	**frequency**	**Medication Education Provided?** ☐Yes ☐No
1)			
2)			
3)			

MEDICATION DISCONTINUED (List med., dosage & frequency)			**REASON FOR MEDICATION DISCONTINUATION**
Medication	**dosage**	**frequency**	**Medication Education Provided?** ☐Yes ☐No
1)			
2)			
3)			

LAB STUDIES, DIAGNOSTIC TESTS AND FREQUENCIES: Metabolic screening done? ☐Yes ☐No Date: _____

COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:

My signature below indicates that I have reviewed the Health Services and Behavior Support Treatment Reports. I have reviewed my recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this review. ***[This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.]***

Physician's Printed Name, Signature and Date:	Clinician: Signature, Title and Date:

Consumer's Consent for Psychotropic Medication: Signature and Date:

Accompanying Person's Printed Name, Signature and Date:

SWALLOWING/DYSPHAGIA SCREEN

Most of us never think of the possibility of not being able to eat or drink safely. It does happen and in very large numbers. *Dysphagia* (dis-FA'jE-a) is the term that means difficulty in swallowing. Many adults with developmental disabilities have or may develop difficulty swallowing.

This screening tool was created to assist you in the identification of possible problems with swallowing. If you fill out this tool and you find several boxes checked, we suggest that you bring it to your case manager, care staff, or physician's attention right away.

- ☐ Frequent episodes of gagging, choking, or coughing
- ☐ Coughing or choking during eating or drinking
- ☐ Excessive drooling
- ☐ Gurgling voice after eating or drinking
- ☐ Watery eyes during or after eating or drinking
- ☐ Frequent upper respiratory infections or pneumonia
- ☐ Swallow food whole
- ☐ Regurgitation after meals, especially while reclining
- ☐ Eating rapidly
- ☐ Difficulty chewing or swallowing
- ☐ Storing food in mouth
- ☐ Loss of food from mouth or nose during or after meals
- ☐ Unusual head or body movements during drinking or eating
- ☐ Difficulty maintaining posture during or after eating

SEIZURE CHART

1. NAME:	DATE:
2. ADDRESS:	TIME: Duration:
3. OBSERVER'S NAME:	LOCATION:

☞Check the appropriate numbers and attach to Incident Reporting form☜

A. Posture at onset of seizure
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Lying Down
- ☐ Other *(see comments)*

B. Color
- ☐ Pale
- ☐ Flushed
- ☐ Blue
- ☐ No Change

C. Level of Consciousness
- ☐ Drowsy
- ☐ Confused
- ☐ Unresponsive
- ☐ Unconscious
- ☐ Other *(see comments)*

D. Eyes
- ☐ Open
- ☐ Closed
- ☐ Rolled Up
- ☐ Fixed Staring
- ☐ Blinking

E. Extremities Involved
- ☐ All Extremities
- ☐ Arms: ☐Right ☐Left
- ☐ Legs: ☐Right ☐ Left
- ☐ Stiff
- ☐ Relaxed
- ☐ Twitching *(mild motor movements)*
- ☐ Jerking *(intense motor movements)*
- ☐ a-Intermittent
- ☐ b-continuous

F. Elimination
- ☐ Individual experienced incontinence
- ☐ Bowel
- ☐ Bladder
- ☐ In Toilet? ☐ Yes ☐ No

G. Breathing
- ☐ Normal
- ☐ Difficult

H. Other Signs
- ☐ Sweating
- ☐ Tongue Biting
- ☐ Dropping of Head
- ☐ Sudden Personality Change
- ☐ Repetitive Purposeless Acts *(see comments)*
- ☐ Facial Twitching
- ☐ Excessive Saliva or Drooling
- ☐ Speech Changes

I. First Aid Care
- ☐ Prevented Fall
- ☐ Actually Intervened to Prevent Fall
- ☐ b-Precautionary Management
- ☐ Supported Head
- ☐ Placed on Side
- ☐ Clothing Loosened
- ☐ Other *(see comments)*

J. After Seizure
- ☐ Alert
- ☐ Drowsy
- ☐ Confused
- ☐ Upset
- ☐ Talkative
- ☐ Brief Sleep, Time: _____
- ☐ Physical Complaint *(see comments)*

K. Injuries
Describe:

L. Injuries
Due to a fall? ☐ Yes ☐ No If *Yes,* what part of body absorbed impact of the fall?

Describe what the person was doing immediately prior to the seizure:
COMMENTS:
SIGNATURE OF PERSON COMPLETING REPORT: DATE:

ANNUAL SEIZURE SUMMARY

Name:	Year:
Type of Seizure(s):	Person completing this form:

Please mark the total number of seizures each day of the month on the chart below:

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															
JUL																															
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															

Total Number of Seizures, by month:

JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

COMMENTS: *(Date and note any medication changes, lab results, significant illnesses, etc. that could possibly effect seizure frequency or severity—use other side if necessary)*

Date completed: _____

Signature: _____

Family HIRS

Section 5

WELLNESS SCHEDULE

ANA Screening Guidelines

Adult Preventive Care Time Line

Years of Age	18	25	30	35	40	45	50	55	60	65	70	75+
Blood Pressure	every 2 years											
Height and Weight	periodically											
Cholesterol	every 5 years											
Hearing										periodically		
Mammography					every 1 to 2 years (women)							
Pap Smear	every 2 to 3 years (women)											
Prostate-specific antigen							anually (men)					
Sigmoidoscopy							every 3 to 5 years					
Stool occult blood							annually					
Urinalysis									periodically			
Dental	annually											
Vision/ glaucoma					every 2 years							
Breast	every 1 to 3 years (women) annually (women)											
Cancer (thyroid, mouth, skin, ovaries, testicles, lymph nodes, rectum [40+], prostate [men, 50+])	every 3 years					annually						
Tetanus-diphtheria	every 10 years											
Pneumococcal										once		
Influenza										annually		
Smoking, alcohol, drugs, sexual behavior, AIDS, guns, family planning, injuries, occupational health, nutrition, physical activity, violence and folate (women 12-45), aspirin (men 40+), estrogen (women 45+)	periodically											

Check up visits with a physician or other health care provider are important for good heath. Most authorities recommend these visits every 1 to 3 years until age 65 and yearly thereafter. Each individual should speak with a physician or other health care provider about the proper schedule of checkup visits. This chart shows the different types of preventative care that are needed at each age. Please note: Recommended intervals for each type of preventative care may vary among authorities. Individuals with special risk factors may need more frequent and additional types of preventative care.

Risk Factor	Preventative Service(s) needed:
Diabetes	Eye, foot examinations, urine test
Drug Abuse	AIDS, TB tests, hepatitis immunization
Alcoholism	Influenza, pnemococcal immunizations, TB
Overweight	Blood sugar test
Homeless, recent refugee immigrant	TB test
High risk sexual behavior	AIDS, syphilis, gonorrhea, chlamydia tests

Health Maintenance Schedule

Type of Visit	Licensing Regulations	Doctor Recommends
Physical Exam	Yearly	Yearly
Eye Exam	Yearly screen with physical	As needed
Dental Exam	Yearly	Every six months
GYN Exam	Yearly with PAP	Yearly with PAP
Hearing Screen	Yearly with physical	Yearly with physical
Skin Check		Yearly
Breast Exam		Monthly
Testicular Exam		Monthly
Blood Pressure	Yearly with physical	Yearly as needed
Mammogram	Every 2 years 40-49, Yearly >50years	Every 2 years, <50 Yearly >50 years
PSA for prostate cancer	Yearly over 40 years with digital exam	Yearly over 40 years with digital exam
Colonoscopy		As recommended by physician

Resource List of Advocacy Groups

Southeast Regional and Statewide

The Advocacy Alliance
877-315-6855 •
www.theadvocacyalliace.org
Our mission is to promote mental wellbeing, prevent mental illness, and advocate for the rights of and provide services to persons who are mentally ill and mentally retarded.

American Council of the Blind
Pennsylvania Chapter:
800-736-1410 • www.trfn.clpgh.org/pcb/
National Office:
800-424-8666 • www.acb.org
The American Council of the Blind is the nation's leading membership organization of blind and visually impaired people. Itwas founded in 1961 and incorporated in the District of Columbia.

The Autism Society of America (ASA)
Greater Philadelphia Chapter:
610-358-5256 • www.asaphilly.org
National Office:
1.800.3AUTISM • www.autism-society.org
The mission of the Autism Society of America is to promote lifelong access and opportunity for all individuals within the autism spectrum, and their families, to be fully participating, included members of their community. Education, advocacy at state and federal levels, active public awareness and the promotion of research form the cornerstones of ASA's efforts to carry forth its mission.

Department of Education
Pennsylvania: www.pde.state.pa.us
National: 800-USA-LEARN •
www.ed.gov

Disabilities Law Project
215-238-8070 • www.dlp-pa.org
The Disabilities Law Project (DLP) is a nonprofit Pennsylvania law firm that provides free legal assistance to people with disabilities, their families, and their organizations. DLP's main purpose is to advocate for the civil rights of persons with mental and physical disabilities, especially their right to live as integral parts of their communities. DLP works to ensure that people with disabilities have equal and unhindered access to employment, transportation, public accommodations, and government services; to enforce their rights to vocational, habilitative, post-secondary educational, health, and other services; and to protect them from abuse and neglect.

Epilepsy Foundation of America
Eastern Pennsylvania Chapter:
800-332-1000
www.epilepsyfoundation.org
National Office:
215-6294997
The Epilepsy Foundation is a national, charitable organization, founded in 1968 as the Epilepsy Foundation of America. The only such organization wholly dedicated to the welfare of people with epilepsy, our mission is simple: to work for children and adults affected by seizures through research, education, advocacy and service.

Health Care Quality Units (HCQU's)
Southeast Regional: Philadelphia
Coordinated Health Care
123 South Broad Street
22nd Floor
Philadelphia, PA 19109
215-546-0300
www.pchc.pmhcc.org

South Central PA:
PNC Bank East Suite
9 West Chocolate Avenue
Hershey, PA 17033
717-531-0528

AE Community Health Connections
101 East Diamond Street
Suite 100
Butler, PA 16001
724-283-0990
www.aechc.org

Central PA:
100 N. Academy Ave.
Danville, PA 17822
570-271-7240
www.geisinger.org

Eastern PA:
744 North 19th Street
Allentown, PA 18104
610-435-2700
www.theadvocacyalliance.org

Northeast PA:
846 Jefferson Ave.
PO Box 1368
Scranton, PA 18501
570-342-7762
www.theadvocacyalliance.org

Health Care Quality Units [HCQUs] serve as the entity responsible to county MR programs for the overall health status of individuals receiving services in the county programs. HCQUs work to support and improve the state MR community system by building capacity and competency to meet the physical and behavioral health care needs of people with developmental disabilities living in Pennsylvania. The primary activities of HCQUs include: assessment of individual health and systems of care; providing clinical health care expertise to counties and residential and day program providers; health related training; integrating community health care expertise to counties and residential and day program providers; health related training: integrating community health care resources with state and regional quality improvement structures and processes and health advocacy. The ultimate goal of the HCQUs is to assure that the individuals served by each county MR program are as healthy as they can be, so that each individual can fully participate in community life.

Learning Disabilities Association of America
Pennsylvania Affiliate: 610-458-8193
www.ldnatl.org/Affiliates/PA/LDAP.htm
National Office: 412-341-1515 •
www.ldantl.org
LDA is the only national organization devoted to defining and finding solutions for the broad spectrum of learning disabilities. LDA is the largest non-profit volunteer organization advocating for individuals with learning disabilities. LDA has 50 state affiliates and more than 600 local chapters in 50 states, Washington DC, and Puerto Rico. Membership totals more than 50,000.

Liberty Resources
www.libertyresources.org
We are a non-profit, consumer driven organization that advocates and

promotes Independent Living for persons with disabilities. More than fifty percent of our board as well as fifty percent of our employees are persons with disabilities.

Parent Education Network
800-522-5827 • www.parentenet.org
PEN is Pennsylvania's statewide Parent Training and Information Center. Much of the information included in this site is designed to support Pennsylvania parents of children with special needs, but information and links are included on Federal Special Education, National Disability Issues and Resources, Special Education Legal Links, Transportation, and Travel that will also pertain to parents and individuals with disabilities in other states.

Parent's Involved Network (PIN)
800-688-4226 • www.pinofpa.org
Parents Involved Network of Pennsylvania (PIN) is an organization that assists parents or caregivers of children and adolescents with emotional and behavioral disorders. PIN provides information, helps parents find services and will advocate on their behalf with any of the public systems that serve children. These include the mental health system, education, and other state and local childserving agencies.

Parent to Parent of Pennsylvania/ Special Kids Network
800-986-4550 • www.parenttoparent.org
Parent to Parent of Pennsylvania is a network created by families for families of children and adults with special needs. We connect families in similar situations with one another so that they may share experiences, offer practical information and/or support.

Pennsylvania Developmental Disabilities Council
717-787-6057 • www.padcc.org
The Pennsylvania Developmental Disabilities Council is a group made up of people with disabilities, family members, advocates, and state department representatives who work to create favorable conditions for people with developmental disabilities and their families in the Commonwealth.

Pennsylvania Education Law Center
215-238-6970 • www.elc-pa.org
The Education Law Center (ELC) is a non-profit legal advocacy organization dedicated to ensuring that all of Pennsylvania's children have access to a quality public education.

Pennsylvania Health Law Project
800-274-3258 • www.phlp.org
PHLP is a nationally recognized expert and consultant on access to health care for low-income consumers, the elderly, and persons with disabilities. For more than a decade, PHLP has engaged in direct advocacy on behalf of individual consumers while working on the kinds of health policy changes that promise the most to the Pennsylvanians in greatest need.

Pennsylvania Parents and Caregivers Resource Network
888-5-PARENT • www.ppcrn.org
We are a statewide cross-disability, grassroots network that supports parents' and caregivers' efforts to help their children and adult family members with developmental disabilities. PPCRN helps them to form local groups and to network with other parents in their regions and across the state. We promote inclusionary practices in all areas of life among parents and caregivers of children and adults with developmental disabilities.

Pennsylvania Protection and Advocacy
717-236-8110 • www.ppainc.org
Pennsylvania Protection and Advocacy, Inc. (PP&A, Inc.) is a federally funded, nonprofit agency responsible for providing protection and advocacy services to people with disabilities.

Pennsylvania Society for the Advancement of the Deaf (PSAD)
www.psadweb.org
PSAD fights discrimination and public misconceptions in our everyday lives by lobbying for the establishment of a deaf/hard of hearing bill of rights with local, state, and federal government through different agencies and organizations.

Pennsylvania Special Education ConsultLine
800-879-2301
www.pde.state.pa.us/special_edu/site/default.asp
Help for families and advocates of children with special needs about special education regulations, school related concerns, and procedural safeguards.

Pennsylvania Vocational Rehabilitation Agency
800-622-2842 • www.dli.state.pa.us
Coordinates and provides counseling, evaluation, and job placement services for people with disabilities.

Speaking for Ourselves
610-825-4592 • www.speaking.org
Speaking For Ourselves, a nonprofit organization, is a pioneer in self-advocacy for people with disabilities. Our mission is to find a voice for ourselves. Teach the public about the needs and wishes and potential of people with disabilities. Speak out on important issues and Support each other through sharing, leadership development and helping and encouraging each other.

Temple University Institute on Disabilities
www.temple.edu/instituteondisabilities
The Institute on Disabilities at Temple University is one of the sixty-one University Centers for Excellence in Developmental Disabilities funded by the Administration on Developmental Disabilities U.S. Department of Health and Human Services.
The mission of the Institute on Disabilities is that, in partnership with people with disabilities, families and allies from diverse

cultures, we work to change systems so that people can live, learn, work and play in the communities of their choice. This mission is accomplished through training, technical assistance, services and supports, research, dissemination, and advocacy.

Visions for Equality
215-923-3349
www.visionforequality.org
A non-profit organization that was established in 1996 for the purpose of providing monitoring and advocacy services for people with mental retardation and their families. Vision for Equality's mission is to assist and empower people with disabilities and their families to seek quality and satisfaction in their lives and equal access to supports and services. Five major program areas are: 1. Embreeville Consumer and Family Satisfaction Teams; 2. court-related and general Advocacy; 3. a Training Department; 4. the Pennsylvania Waiting List Campaign including community education services; 5. Independent Monitoring for Quality (IM4Q).

National

American Cancer Society
1-800-ACS-2345 • www.cancer.org
The American Cancer Society (ACS) is a nationwide, community-based voluntary health organization. With chartered divisions throughout the country and over 3,400 local offices, the American Cancer Society (ACS) is committed to fighting cancer through balanced programs of research, education, patient service, advocacy, and rehabilitation.

Americans with Disabilities Act Information
www.usdoj.gov

The ARC
301-565-3842 • www.thearc.org
The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The association also fosters research and education regarding the prevention of mental retardation in infants and young children. The Arc is people - people with mental retardation and related developmental disabilities, parents and other family members, and friends of people with mental retardation and professionals who work with them.

CONNECT Information Service
800-692-7288

The Consortium for People with Developmental Disabilities
202-783-2229
www.c-c-d.org
The Consortium for Citizens with Disabilities is a Coalition of national consumer, advocacy, provider and professional organizations headquartered in Washington, D.C. Since 1973, the CCD has advocated on behalf of people of all

ages with physical and mental disabilities and their families. CCD has worked to achieve federal legislation and regulations that assure that the 54 million children and adults with disabilities are fully integrated into the mainstream of society.

Council for Exceptional Children
703-620-3660 • www.cec.sped.org
Pennsylvania CEC: www.pfcec.org
The Council for Exceptional Children (CEC) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted. CEC advocates for appropriate governmental policies, sets professional standards, provides continual professional development, advocates for newly and historically underserved individuals with exceptionalities, and helps professionals obtain conditions and resources necessary for effective professional practice.

Easter Seal Society
SE Pennsylvania:
www.easterseals-sepa.org
National: 312-726-6200 • www.easter-seals.org
Easter Seals has been helping individuals with disabilities and special needs, and their families, live better lives for more than 80 years. Whether helping someone improve physical mobility, return to work or simply gain greater independence for everyday living, Easter Seals offers a variety of services to help people with disabilities address life's challenges and achieve personal goals.

EDLAW
www.edlaw.net
The EDLAW Center was established to provide assistance on a systemic level to attorneys who represent parents of children with disabilities. It is premised on the recognition that, while securing an appropriate education for any single child with a disability is important, changes on a systemic level are necessary to enable all children with disabilities to obtain the free appropriate public education promised to them by the law.

IDEA Practices
877-CEC-IDEA • www.ideapractices.org
The IDEA Partnerships are four national projects funded by the U.S. Department of Education's Office of Special Education Programs (OSEP) to deliver a common message about the landmark 1997 reauthorization of the Individuals with Disabilities Education Act (IDEA). The IDEA Partnerships, working together for five years, inform professionals, families and the public about IDEA '97 and strategies to improve educational results for children and youth with disabilities.

National Down Syndrome Congress
1-800-232-NDSC • www.ndsccenter.org
The purpose of the NDSC is to promote the interests of persons with Down syndrome and their families through advocacy, public awareness, and information dissemination on all aspects of Down syndrome. The NDSC is financially supported primarily through membership dues and individual contributions.

National Down Syndrome Society
800-221-4602 • www.ndss.org
The National Down Syndrome Society was established in 1979 to ensure that all people with Down syndrome have the opportunity to achieve their full potential in community life. Since that time, this not-for-profit organization has become the largest non-governmental supporter of Down syndrome research in the United States.

National Organization on Disability
202-293-5960 • www.nod.org
The National Organization on Disability, celebrating its 20th anniversary in 2002, promotes the full and equal participation and contribution of America's 54 million men, women and children with disabilities in all aspects of life.

Reed Martin, JD – Special Education Law
www.reedmatin.com
Reed Martin is an attorney with over 34 years experience in special education law and recognized as one of the nation's leading experts.

Tourette Syndrome Association
718-224-2999 • www.tsa-usa.org
Founded in 1972 in Bayside, New York, the Tourette Syndrome Association, Inc., or TSA, is the only national voluntary non-profit membership organization in this field. Its mission is to identify the cause of, find the cure for and control the effects of this disorder.

United Cerebral Palsy
800-872-5827 • www.ucpa.org
UCP is the leading source of information on cerebral palsy and is a pivotal advocate for the rights of persons with any disability. As one of the largest health charities in America, UCP's mission is to advance the independence, productivity and full citizenship of people with cerebral palsy and other disabilities.

US Office of Special Education Programs
202-205-5507•
www.ed.gov/offices/OSERS/OSEP/
OSEP is dedicated to improving results for infants, toddlers, children and youth with disabilities ages birth through 21 by providing leadership and financial support to assist states and local districts.

Wright's Special Education Law
www.wrightslaw.com
Parents, advocates, educators, and attorneys come to Wrightslaw for accurate, up-to-date information about advocacy for children with disabilities. You will find hundreds of articles, cases, newsletters, and resources about special education law and advocacy in the Advocacy Libraries and Law Libraries.

Medical History Summary Worksheet

Name:

Address

Provider Agency:

Phone:

D.O.B.:

Social Security #:

Primary Physician - name, address, phone
Dentist - name, address, phone
Guardian/Emergency Contact– name, address, phone

Overview

Age:
Comments: e.g. well developed, pleasant
Race:
Sex:
When ind. came to agency:
Current residence: e.g. lives with one other gentleman
Describe residence: clean, neat
Amount of supervision:
Status with ADL's: e.g. independent but needs reminders about personal grooming
Social: e.g. very social, quiet, withdrawn
Communication: expressive & receptive

e.g. non-verbal but communicates well by ...

- can communicate verbally
- can communicate his needs
- communication skills are limited
- good communication skills

Vision:
Hearing:
Activity Level:
Gross & Fine Motor Skills:
Adaptive Equipment:
Job/Workshop (include means of transportation there and specifics about job):
Sleeping Habits:
Diagnoses (include level of mental retardation, chronic medical conditions):
Medication Administration (does the individual administer their own medications)

Developmental Information

Length of gestation (weeks/months):
Birth Weight:
Mother's health during pregnancy:
Labor length:
Instruments used during delivery:
Early Development: walking
speaking
toilet training
e.g. walked without support at 36 months
When delays noted:
Etiology of disability:
Childhood illnesses:

Family Social Information

Date born:
Place born (hospital, city):
Status in family: e.g. Patty is one of four children
Patty is the second child of 7 children
Parents names:
Siblings and ages, MR status:
Family info: e.g. occupations if known, mother died in _____ of _____, parental and sibling health issues
Raised by:
Comments by individual about family life:
How long lived at home:
When institutionalized:

Past Medical History

Where information was obtained: e.g. taken from Pennhurst Discharge Summary and CLA documentation from 1990 to present.

Eyes:

List diagnosis and date diagnosed if available (e.g. compound myopia O.U.):
Glasses (e.g. new prescription in 1/97, individual wears glasses at all times)

Dates of visits and evaluation results (if relevant, e.g. ® cataract diagnosed in 5/97 with no treatment needed at present time or ophthalmologic exam on 4/97 with no abnormalities noted)

Ears, Nose and Throat:

List any conditions (e.g. bilateral sensorineural hearing loss, tonsillitis, laryngitis, sinusitis):

Comment on status (e.g. hearing screened by primary care physician at annual physical exam with no abnormalities noted):
Dates of visits and evaluation results (e.g. 1/97 - audiology screen with no abnormalities noted):

Respiratory System:

Comment on status and list any conditions (e.g. emphysema, chronic obstructive pulmonary disease, asthma, history of pneumonia)
Any chest x-rays with results:
Specific infections or problems (e.g. recurrent upper respiratory infections):
List any therapies used (e.g. oxygen, bronchodilators)

Cardiovascular System:

Comment on status and list any conditions (e.g. cardiac conditions, hypertension, history of murmurs)
Any EKG results:

Digestive System:

List current height and weight, give weight history if obesity is a chronic condition:
List if currently on prescribed diet:
List any conditions (e.g. gastro-esophageal reflux disease (GERD), hyperlipidemia, hemorrhoids, liver disorders):
Elimination problems:
Liver function studies:

Genito-urinary System:

Comment on status and list any conditions (e.g. recurrent urinary tract infections, urinary incontinence, prostatitis):
Females: Mammogram, PAP, gyn visits and results:
Males: Prostate examination (over 40 years of age):
Lab results (e.g. urinalysis, BUN, creatinine):

Nervous System:

List any conditions (e.g. stroke, Alzheimer's disease, multiple sclerosis, Parkinson's disease, trauma):
List mental retardation, level of retardation, etiology:
History of seizures, current activity, type of seizure:
EEG results:

Musculoskeletal System:

Comment on status and list any conditions (e.g. arthritis, bursitis, trauma (sprains, dislocations, fractures), curvature of spinal column):
History of fractures/sprains and treatment:

Endocrine System:

Comment on status and list any conditions (e.g. disorders of adrenal gland, thyroid gland, pituitary gland, pancreas, diabetes):
Lab results (e.g. thyroid function studies, blood glucose level)

Lymphatic System:

Comment on status and list any conditions:
Edema:
Lymph nodes:

Integumentary System (skin, nails, hair):

Comment on any conditions of skin, nails, hair (e.g. cellulitis, dermatitis, pigmentations, tinea, diseases of the nails) and treatments:

Psychiatric/Behavioral

Past psychiatric diagnosis:
Synopsis of medication usage, including positive or negative reactions:
Behaviors that interfere with health or safety:
Past therapeutic interventions and results:
Current diagnosis and therapies:
Date of last psychological evaluation:

Dental

Comment on overall status (e.g. good dental hygiene with multiple missing teeth):
Comment if individual has dentures and if not, why (e.g. dentures were obtained in 1/97 but individual refuses to wear them):

Immunizations

Hepatitis Status (list date and results of screening; if immunized, give dates):
TB Status (list date and results of last screen using Mantoux method):
Tetanus/Diphtheria Status (list date of booster):

If individual has received Pneumovax (pneumonia vaccine) it can be listed here as well.

Allergies/Sensitivities

List agent and reaction (include food as well as drug allergies/sensitivities, sun sensitivity):

Current Health Status

List all diagnoses:

Current Medications

List current meds, dosage, frequency, route and reason (e.g. Dilantin 100 mg. three times a day at 7 AM, 1 PM and 7 PM orally - seizures):

Medical History Summary submitted by:

_____ _____

Name/Title: Date

Health Promotion Activities Plan

This sample is to assist you in developing a health promotion activity plan. It is not intended to replace medical advice. Any instructions given by the physician regarding this diagnosis must be included.

Name of Individual:

Health Concern/Issue * (Diagnosis)	**CERUMEN (EAR WAX) BUILD-UP, CHRONIC**
Related Body System	Vision Respiratory Lymphatic Dental **Hearing** Digestive Integumentary (Skin) Endocrine Cardiovascular Nervous Musculoskeletal Genitourinary Blood
What is it? (Provide definition)	Blockage of the ear canal with ear wax.
Signs and Symptoms (general)	Difficulty hearing, earache, fullness in ear or sensation the ear is plugged, noise in the ear
Signs and Symptoms (specific to the person)	
Promotion/strategy support required * List very specific steps that the individual and/or caregivers use to support the person's health condition. Include information about monitoring health status. Who is called for changes/ problems in this person's health condition? What is tracked, where it can be found, and who follows up on documentation required for this health condition? Who provides what training for the person and staff about the health condition and when?	➢ Watch *(name of person)* for signs and symptoms listed above and report to *(title of person in agency who is responsible to receive this information).* ➢ Give medication as ordered (see Medication Administration Record/Log). If a prn (as needed) medication is given, the result must be documented per agency policy. ➢ Documentation about this condition can be found in the medical record under *(list section here)*. ➢ Receive training regarding this diagnosis and plan of care (include when to notify the physician) by *(title of person who provides medical training)* at least *(indicate frequency of training)* or as changes occur. This should be documented for all staff in the home.
Frequency of support *	*Fill in what physician (e.g. primary care physician, ENT) treats this condition and how often the person is seen.*
Desired outcome *	To recognize symptoms as soon as possible and obtain treatment.
Person/agency responsible *	*(Name of person)*, caregivers, agency nurse, primary care physician, *(specialist, if applicable)* *(The responsible parties may vary according to your agency; please place specific roles in this section. Some other examples might be health care coordinator, program specialist, house manager.)*

* FIELDS FOUND IN THE HEALTH PROMOTION SECTION OF THE ISP

PHILADELPHIA COORDINATED HEALTH CARE

123 S. Broad Street, 22nd Floor • Philadelphia, PA 19109
(215) 546-0300 • Fax: (215) 790-4976
The Southeastern Pennsylvania Health Care Quality Unit

The PCHC Integrated Health Clinical Review

This team of medical and behavior health professionals use a multidisciplinary and integrated approach to assist teams challenged with supporting people with intellectual disabilities who present with difficult psychiatric and behavioral issues.

Documentation Requirements for Integrated Health Clinical Reviews

A **Team Agreement Form** and other necessary documentation are required to schedule the Integrated Health Clinical Review. To use our time as effectively as possible, we want as much information about the person for whom the review is being done before we actually meet with the person and the person's team.

Please check off the boxes below as you put together the documentation packet for PCHC and use the documentation request form as your cover sheet.

If you think any additional information beyond what is requested below would be helpful, please send it.

☐	Most recent ISP	☐	Current medications and medication history (for history, list all medications, why prescribed , date started, date discontinued and why discontinued)
☐	Lifetime Medical History (include all chronic health conditions)	☐	Results of all health related testing (e.g. imaging results, EKG, EEG, genetic assessment etc.)
☐	Results of most recent physical examination	☐	***PCHC Family Health History* and Behavioral Health Information Form(attached)***
☐	Results of all health consultations (e.g. neurological, gastroenterology, ENT, speech, mobility etc.)	☐	Last four Team Review of Psychotropic Medications (formerly 90 day forms)
☐	Records for all hospital assessments and discharges	☐	All current and previous Behavior Plans, Plans of Support or Social Emotional Environmental Protocols (SEEP) including supporting data
☐	All lab work for last 2 years	☐	All incident reports/Unusual incidents in the past year.
☐	All Psychological and Psychiatric Evaluations	☐	All documentation from past and present providers

***Because family health history is so important, a Family Health History Form is provided to be filled out and returned.**

Once requested documentation is received, the next available date for the clinical consult will given to the person's team.

We welcome and recommend everyone involved with the selected individual attend the review (family, direct staff, behavior specialist, therapist etc.).

The person being reviewed needs to be present for at least a short time for us to complete a full review.

Please mail or fax: the Team Agreement Form and other documentation:

Team Agreement Forms go to:
Peggy Cragin
Philadelphia Coordinated Health Care
123 South Broad Street, 22nd Floor
Philadelphia, PA 19109
Phone: 215-546-0300 Ext. 3662
Fax: 215-790-4976

All Integrated Health Clinical Review Documentation goes to:
Shani Jackson
Philadelphia Coordinated Health Care
123 South Broad Street, 22nd Floor
Philadelphia, PA 19109
Phone: 215-546-0300
Fax: 215-790-4976

PHILADELPHIA COORDINATED HEALTH CARE

123 S. Broad Street, 22nd Floor • Philadelphia, PA 19109
(215) 546-0300 • Fax: (215) 790-4976
The Southeastern Pennsylvania Health Care Quality Unit

Behavioral Health Information Form

Please complete this information and submit with the PCHC Documentation Request Form, PCHC Family Health History Form and other documentation pertaining to the individual as you put together the documentation packet for a PCHC Clinical Consult.

Name of Person to be Reviewed:_____ **Date:**_____

Behavioral Health Insurance:

____CBH ____Magellan _____Private Pay Psychiatrist ____CCBH
____PCP prescribes psychotropic medication

Does the person have a Behavior Specialist Consultant? YES NO
Name of Behavior Specialist Consultant:_____
Behavior Specialist Consultant contact information:_____

Does the person have a Plan of Support/Social, Emotional, Environmental Protocol? YES NO
If YES, please submit documentation

Does the person have a Behavior Support Plan? YES NO
If YES, please submit documentation

Does the person have a Certified Peer Specialist? YES NO

Does the person have an individual therapist? YES NO
Therapist's Name and Agency_____

Does the person attend group therapy sessions? YES NO

Does the person have a Wellness Recovery Action Plan (W.R.A.P.®)? YES NO

Does the person have an attending psychiatrist? YES NO
Name of attending psychiatrist:_____
Attending psychiatrist contact information_____

Does the person currently have 1:1, 2:1 or 3:1 staffing? YES NO
If yes, please circle which one: 1:1 2:1 3:1

Are there any current additional restrictive procedures (restraints, level systems, psychotropic PRN's etc.) being utilized or authorized for this person? YES NO

If so, please describe_____

_____