PRE - APPOINTMENT QUESTIONNAIRE (PAQ)

PLEASE COMPLETE ALL SECTIONS AND RETURN TO:

Centre for Developmental Disability Health
67 Power Road
DOVETON VIC 3177
Telephone: (03) 9792 7888

Important: Before you complete the Pre-Appointment Questionnaire (PAQ)

CDDH clinics are for people aged 18 years and over who have an intellectual disability.

CDDH is not an ongoing care service. A report will be sent to the GP within 2-4 weeks of the consultation with management advice. It is expected that the patient make an appointment with the GP to discuss and follow up the suggestions.

Clinicians at the Centre for Developmental Disability Health (CDDH) will review information in this PAQ as part of their assessment of the patient for an appointment at CDDH. To ensure the best use of time for the patient at the appointment, please complete this questionnaire. Use the checklist on the next page to ensure that you have included all relevant information.

Please note: pages 17- 20 must be completed by the patient's GP.

CDDH provides clinical consultations and comprehensive assessments by medical practitioners with expertise in the health issues of people with developmental disability across Victoria in order to support the person's usual treating doctor and other community based health services to provide ongoing care**.** Patients may be seen by a general practitioner, a psychiatrist or a psychiatry trainee under psychiatrist supervision.

CDDH **does not** provide an emergency or crisis service. Should the person require urgent medical or psychiatric treatment you should either:

1. Contact the person's usual treating doctor
2. Arrange for the person to be taken to a hospital emergency department
3. Contact the local Area Mental Health Service

Use of the information gathered in this form.

The information gathered in this form is used for patient care. Some of the information obtained from this form and during consultations may also be used, in a de-identified format, for statistical, planning, educational and research work done by the CDDH. This information will not identify you in any way. If you have concerns about this, please talk about them with the doctor. Your decision will in no way affect any services you receive from the CDDH.

PAQ COMPLETION CHECKLIST

A) The person who completes the PAQ is clearly identified and contact details are provided. The section on Key Contact People is completed. Yes ☐

B) The Medical Treatment Decision Maker (MTDM) is aware of the application for an appointment with the CDDH and that their attendance at the appointment would be welcome. Yes ☐

If not, please explain why not: …….

Please note that any changes to medical treatment must be approved by the MTDM. The MTDM, as specified by the Office of the Public Advocate, is the first person in the list below who is reasonably available, and willing and able to make the decision:

1. A medical treatment decision maker appointed by the patient.
2. A guardian appointed by VCAT to make decisions about medical treatment.
3. The first person in the list who is in a close and continuing relationship with the patient: the patient's spouse or domestic partner, the patient's primary carer (**not a paid service provider**), an adult child of the patient, a parent of the patient, an adult sibling.

NB If there are two or more relatives who are first on the list, it is the eldest person.
NBB Before the Medical Treatment Planning and Decisions Act commenced in 2018, the patient may have appointed someone to make medical treatment decisions in a medical enduring power of attorney, an enduring power of attorney, or enduring power of guardianship. These appointments are still valid.

C) The MTDM has given *written consent* to have medical information released to relevant third parties. If so, please bring a copy of this letter for our records. Yes ☐

D) All relevant information is provided and relevant reports are attached including the list of medications Yes ☐

E) Treating doctor has reviewed Part A and signed the Medication list Yes ☐

F) Treating doctor has completed pages 17 -20 and signed Part B Yes ☐

G) Doctor has indicated an evaluation by a CDDH Psychiatrist may be required. Yes ☐
***Note**: If the presenting issue is a **problem with behaviour, a psychiatric referral is advised**. CDDH psychiatrists **cannot** see patients without a valid referral.*

Clinic review meeting notes

For office use only

PRE - APPOINTMENT QUESTIONNAIRE

❖ PERSONAL INFORMATION

Name: _____
GIVEN NAMES **SURNAME**

Date of Birth: ____ ____ / ____ ____ / ____ ____ Sex: Male ☐ Female ☐

Medicare number: ☐☐☐☐ ☐☐☐☐☐ ☐ Pt Ref No.☐ Valid to _____

Residential Address: _____
_____

Postcode: _____ Phone: _____

Current address: _____
(if not the same as above)
Postcode: _____ Phone: _____

Is the patient of Aboriginal but not Torres Islander Background? YES ☐ NO ☐

Is the patient of Torres Islander but not Aboriginal Background? YES ☐ NO ☐

In which country was the patient born? _____

Marital Status: Married ☐ Divorced ☐ Single ☐
Separated ☐ Widowed ☐ Defacto ☐

❖ HOW DID YOU FIND OUT ABOUT THE CDDH?

GP or other medical practitioner ☐ DHHS ☐

House staff/day placement staff ☐ Non-government Disability Service ☐

Family/friend ☐ CDDH website ☐

Victorian Dual Disability Service ☐ Other ☐

If other, please specify: _____

❖ REASON FOR REQUESTING A REFERRAL

Who originally requested that the patient be assessed by the CDDH?

Name: _____

Address: _____

Postcode: _____

Home phone: _____ Mobile: _____

What is that person's position/relationship in regard to the patient? (eg parent, Case Manager).
Please specify: _____

REASON: Please give <u>full details of the reason(s)</u> for this request for a consultation.
What is the problem? How urgent or serious is the problem? What has already been tried? Why is the CDDH seen as appropriate?
NOTE: This information is <u>important</u> for the clinical team considering the referral.

(Please include additional pages to continue if there is insufficient room here)

❖ KEY CONTACT PEOPLE

In order to ensure the patient's complete care, a copy of our report will be sent to the patient, the GP, the house supervisor and any other health professionals directly involved in the patient's care. Please list their contact details below, as well as anyone else you feel would benefit from seeing the report.

Role	**Name**	**Address (incl. postcode)**	**Phone**	**Fax**
Medical Treatment Decision Maker				
House supervisor				
Day placement				
NDIS support coordinator				
GP				
Other (specify):				
Other (specify):				
Other (specify):				

❖ COMMUNITY/GOVERNMENT SUPPORTS

What supports are currently used?

Respite care	☐	Physiotherapist	☐
In-home support	☐	Dietician	☐
Speech Therapist	☐	Other	☐

Please specify other: _____

Is the patient registered with the Department of Health and Human Services?
YES ☐ NO ☐ UNKNOWN ☐

Has the person got a Person Centred Plan (PCP)? YES ☐ NO ☐ UNKNOWN ☐

Please bring the most recent Person Centred Plan: _____

Does the patient have an NDIS plan? YES ☐ NO ☐

If YES, please bring a copy of the NDIS plan to your appointment.

❖ COMMUNICATION

What are the patient's communication abilities?

Receptive communication - How well does the patient understand others? (tick one)

Good comprehension ☐ Poor comprehension ☐ Unknown ☐

Expressive communication - How does the patient express themselves? (tick one or more)

Clear speech	☐	Electronic communication device	☐
Unclear speech	☐	Formal sign language	☐
Vocalisation	☐	Informal - gesture, facial expressions	☐
Communication book or board	☐	Through their behaviour	☐

Is the patient of a Non English Speaking Background? (NESB) YES ☐ NO ☐
If yes, what is the patient's first language? _____

If a consultation is recommended, is an **interpreter,** or other assistance with communication required at the consultation? YES ☐ NO ☐

If YES: ***If an assessment is recommended by the CDDH clinical team and an interpreter or other assistance with communication is required, please discuss this with the CDDH Clinic Coordinator when arranging the appointment.***

❖ MOBILITY

Does this patient use a walking aid? YES ☐ NO ☐

Does this patient use a wheelchair? YES ☐ NO ☐

Does this patient require a hoist for transfers? YES ☐ NO ☐

❖ ACCOMMODATION

What is the nature of this patient's permanent accommodation? (tick one)

Alone, independent	☐	Special respite service	☐
With parents / relatives	☐	Hostel	☐
With spouse / partner / friend	☐	Other (Please give details)	☐
Institution	☐		
Nursing home / hospital	☐		
SSA (DHHS group home)	☐		
Group Home (non Govt)	☐		

How long has the patient lived at their current accommodation? _____

If the patient has previously lived in an institution(s), please name it/them.

Name of previous institution(s): _____

❖ DEVELOPMENTAL DISABILITY

Does this patient have any of the following <u>developmental disabilities</u>? (tick if yes and give details)

Intellectual ☐

Physical ☐
eg Cerebral Palsy/Spina Bifida

Sensory ☐
eg visual/hearing impairment

Social ☐
eg Autism spectrum disorder

CAUSE of disability: Please give any information that is known about the nature and cause of the disability:

_____

❖ INTELLECTUAL DISABILITY

If this patient has an <u>intellectual disability</u> is the <u>level</u> of the intellectual disability known?

(If yes, please tick the appropriate level) YES ☐ NO ☐

Borderline ☐ Mild ☐

Moderate ☐ Severe ☐

Profound ☐

Is this based on a formal IQ assessment? YES ☐ NO ☐ UNKNOWN ☐
If yes, please give details eg when, where, what type of test, results etc.

_____

Is the CAUSE of the intellectual disability known? YES ☐ NO ☐
UNKNOWN ☐

Cause if known: _____

Has this patient had genetic testing? YES ☐ NO ☐ UNKNOWN ☐

If yes, please give date and results: _____

Has this patient had a Fragile X screen? YES ☐ NO ☐ UNKNOWN ☐

If yes, please give date and results: _____

If yes, please give details: _____

❖ FAMILY / SOCIAL HISTORY

Is there a family history of developmental disability?
YES ☐ NO ☐ UNKNOWN ☐
If yes, please give details: _____

Is there a family history of any other medical conditions, including mental health problem or psychiatric illness? YES ☐ NO ☐ UNKNOWN ☐

If yes, please give details: _____

❖ ACTIVITIES / OCCUPATION?

What is the patient's current occupation? (tick one or more)

Day activity support service ☐ TAFE ☐

School ☐ Supported employment ☐

Open employment ☐ Retired ☐

Other ☐ Nothing (none) ☐

Name of school/workplace/day service etc: _____

Social activities/interests/hobbies: _____

❖ INDEPENDENCE SKILLS

Please indicate this patient's level of skill in the following areas: (tick in relevant box)

Skill Area	Independent or almost independent	Needs support or assistance	Totally or almost totally dependent
Eating/drinking			
Dressing			
Toileting/ bathing/ personal hygiene			
Money handling			
Travel (public transport)			

Further details about skills: (eg loss of skills, particular strengths) _____
_____
_____
_____

MEDICAL INFORMATION AND BACKGROUND

1. CURRENT MEDICAL PROBLEMS OR ISSUES (Please List)

_____
_____
_____
_____
_____
_____

2. PAST MEDICAL CONDITIONS OR OPERATIONS

Please list any known (including psychiatric conditions or mental health problems).

Condition or operation	Age or year	Details – where, why etc

3. EPILEPSY

Does this patient have epilepsy? YES ☐ NO ☐ UNCLEAR ☐

If yes, date of last seizure _____

Seizure pattern (eg how often?, in cycles?, time of day?) _____

_____

Name of seizure type (if known) _____

Description of seizure _____

_____

Is a seizure chart kept? YES ☐ (please bring to appointment) NO ☐

Is an EEG result available? YES ☐ (attach a copy if available) NO ☐

Has this patient had a CT/CAT scan? YES ☐ (attach a copy if available) NO ☐

4. CURRENT MEDICATIONS

Please complete the table below or attach a copy of the **list of current medications and allergies** from the patient's GP. If the patient has a Webster pack please also attach a copy of the **pharmacist's current list of medications**.

Note: Please ask the Referring Medical Practitioner to check and change as indicated.

Medication	Dosage	Times given (times/day)

5. PREVIOUS SIGNIFICANT MEDICATIONS

Please list any known previously used significant medication, (eg anti-convulsant, sedatives).

Why were they used? Why were they stopped?

_____

_____

6. ALLERGIES or ADVERSE DRUG REACTIONS

List any drugs or other substances this patient is allergic or sensitive to.

Substance	Reaction

Please ensure that the referring medical practitioner reviews the medication prior to forwarding this form.

This information regarding current and previous significant medication, allergies and adverse reactions is correct.

DOCTOR'S SIGNATURE: _____ DATE: _____

7. SCREENING TESTS and PREVENTIVE CARE

Please give dates (actual or approximate) for the following (as relevant):

- Most recent vision / eye assessment / /
- Most recent hearing assessment / /
- Most recent dental review / /
- Most recent general health check-up / /
- Most recent blood pressure check / /
- Most recent Pap smear (if relevant) / /
- Most recent breast check/mammogram / /
- Most recent testicular check / /
- Most recent prostate check / /
- Most recent Influenza immunisation / /

Is the patient up to date with all recommended immunisations? YES ☐ NO ☐
Details: _____

8. HEALTH RISK FACTORS AND CONCERNS

Are any of the following considered to be a problem/issue for this patient?
(Tick all appropriate options and provide any further information known)

Weight: Underweight _____ kg ☐ Overweight _____ kg ☐

Diet ☐

Dental health ☐

Smoking - _____ /day ☐

Alcohol - _____ /day ☐

Illicit drugs ☐

High blood pressure ☐

Lack of exercise ☐

Behavioural problem ☐

Forensic issues ☐

Access to services ☐

Mobility problems ☐

Sleep problems ☐

Continence problems ☐

Human relations / sexual issues ☐

Loss of abilities or skill ☐

Other (please give details) ☐

❖ PROBLEM BEHAVIOUR DETAILS

*Please complete this section **if Behaviours of Concern** is a reason for this referral.*

Please complete box for each type of behaviour the person has.

Type of Behaviour:

1. HURTFUL TO SELF YES ☐ NO ☐

- *Definition - behaviour which causes actual tissue damage or illness to the individual as evidenced by bruising, vomiting, lacerations etc*
- *For example - hitting self, head banging, hair pulling, cutting, skin picking, pica, self-induced vomiting*
- Describe the problem behaviour: _____

  _____

  _____

  _____
- Frequency of behaviour: _____
- Severity: _____
- When/why did the behaviour become a problem? _____

  _____

  _____

2. HURTFUL TO OTHERS YES ☐ NO ☐

- *Definition - behaviour which causes actual tissue damage to other people as evidenced by bruising, lacerations etc*
- *For example - hitting with hands, head butting, hair pulling, biting, kicking, punching, throwing things, pinching*
- Describe the problem behaviour: _____

  _____

  _____

  _____
- Frequency of behaviour: _____
- Severity: _____
- When/why did the behaviour become a problem?

  _____

  _____

  _____

  _____

  _____

3. DESTRUCTIVE TO PROPERTY YES ☐ NO ☐

- *Definition - behaviour which causes property to be damaged, defaced or destroyed*
- *For example - smashing, tearing, cutting, burning, scratching, unpicking, throwing, dismantling*
- Describe the problem behaviour: _____

  _____

  _____

  _____
- Frequency of behaviour: _____
- Severity: _____
- When/why did the behaviour become a problem?

  _____

  _____

  _____

  _____

4. SOCIALLY UNACCEPTABLE BEHAVIOUR YES ☐ NO ☐

- *Definition - behaviour which does not cause tissue damage to self or others but severely limits the patient's access to ordinary settings, activities, services and experiences*
- *For example - public masturbation, sexual touching, stealing, loud vocalising, screaming, spitting, verbal abuse or threats*
- Describe the problem behaviour: _____

  _____

  _____

  _____
- Frequency of behaviour: _____
- Severity: _____
- When/why did the behaviour become a problem?

  _____

  _____

  _____

  _____

5. EXTREME WITHDRAWAL/ INATTENTIVE BEHAVIOUR YES ☐ NO ☐

- *Definition - behaviours which severely interfere with or limit social interaction with the patient*
- *For example - keeping away from others, fearfulness, showing no interest, refusing to get out of bed, ritualistic or stereotypic behaviours*
- Describe the problem behaviour: _____

  _____

  _____

  _____
- Frequency of behaviour: _____
- Severity: _____
- When/why did the behaviour become a problem?

  _____

  _____

  _____

  _____

- What interventions or services have been used in relation to these behaviours, and what was the outcome of these? PLEASE TICK AND GIVE DETAILS BELOW

BSS (Behaviour Support Services) ☐ Psychologist ☐

Family Counselling ☐ Psychiatrist ☐

Other ☐ VDDS (Victorian Dual Disability Service) ☐

_____

_____

_____

_____

- If this patient had contact with Area Mental Health Services or the Criminal Justice System please briefly explain:

_____

_____

_____

MONASH University
Medicine, Nursing and Health Sciences

CDDH VICTORIA *Better Health Better Lives*

Depression in adults with intellectual disability

Checklist for carers

FOR EACH ITEM/SYMPTOM YOU HAVE OBSERVED IN THIS PERSON:

Circle L if the item/symptom has been present over a Long period of time

Circle C if there is a Change. This means that the item/symptom is new or has increased in severity for 2 weeks or longer

Circle both L and C if an item/symptom has been present for a long time but has increased in severity for 2 weeks or longer

If item not present, please leave blank.

Name: _____ Date of birth: / /

Person completing form: _____ Date of completion: / /

Relationship to the client: _____

Talking about wanting to die, suicide, or suicide attemp	L	C
Depressed mood		
Crying more often or more easily	L	C
Looks sad or unhappy or depressed or downcast	L	C
Less or lack of emotional response or expressiveness	L	C
Less or no smiling	L	C
Less or lost sense of humour – Less or no laughing	L	C
Depressed thinking		
Talking about sad things, death or dying	L	C
Talking about being bad or no good	L	C
Saying that people don't like them or are picking on them	L	C
Expressing concerns about their health or their body	L	C
Loss of interest in or enjoyment in usual activities		
Not enjoying activities that are usually enjoyed	L	C
Can't be cheered up with enjoyable activities or treats	L	C
Refusing, reluctant or needs persuasion to get out bed	L	C
Refusing, reluctant or needs persuasion to attend day placement	L	C
Refusing, reluctant or needs persuasion to do usual activities	L	C
Irritability		
Irritable, short tempered	L	C
Temper tantrums	L	C
Verbally abusive	L	C
Physically threatening	L	C
Physical assault of others	L	C
Property damage	L	C
Anxiety		
Appears anxious, fearful	L	C
Seeking reassurance	L	C
Repetitive questioning	L	C
Repetitive behaviours, rituals or obsessions	L	C
"Clinging" behaviour	L	C
Increased or new fear of lifts, escalators, crowds, other	L	C
Whinging, whining, worrying	L	C

Loss of confidence	L	C
Agitation, restlessness	L	C
Social interaction and communication		
Less or avoiding eye contact	L	C
(More) Withdrawn, not interacting with others	L	C
Spending (more) time alone	L	C
Decreased communication by signs or gesture	L	C
Not talking as much, not engaging in conversation, short or no answers	L	C
Long pauses or slow to answer	L	C
Slumped posture	L	C
Sighing more often	L	C
General functioning		
Appears to be slowed up, taking longer to do things	L	C
Listless, lacking in energy, motivation	L	C
Loss of skills and abilities	L	C
Less able to concentrate on or complete tasks	L	C
Not paying attention	L	C
Self neglect in dressing, grooming and showering/bathing	L	C
Appetite/ Weight		
Loss of appetite, refusing food, picky with food	L	C
Loss of weight	L	C
Increased appetite	L	C
Increased weight	L	C
Sleep		
Sleeping more or too much	L	C
Having trouble going to sleep, sleeping less, waking up during the night,	L	C
Waking up earlier than usual	L	C
Other behaviours		
Self injury	L	C
Other (please specify)		
	L	C
	L	C
	L	C

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

PART A completed by: _____ Date completed: _____

Position / relationship to patient: _____

Other information sources consulted: _____

_____

_____

Would you like to receive information on the Centre for Developmental Disability Health Victoria, its services & products? YES ☐ NO ☐

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

THANK YOU FOR COMPLETING THIS FORM.
The information you have provided will enable us to better understand the presenting health issues

* After PART A is completed please take the Pre-Appointment Questionnaire **with the patient** to the referring Medical Practitioner.

* Please make an appointment for a **long/double consultation** so the doctor has time to complete this form.

* Ask the referring Medical Practitioner to **review and sign Part A** and **complete Part B.**

* It is important that the patient attends this consultation for examination and is accompanied by a carer who knows them well.

* Information from a recent **Annual Health Assessment** may be used to help with this referral.

* Take along a clean fresh urine specimen if possible.

* Take along any medical reports or information you have at home.

When both PART A and PART B have been completed return the form to:

Centre for Developmental Disability Health
67 Power Road
DOVETON VIC 3177

You will be contacted after the Pre-Appointment Questionnaire and other information has been considered by the CDDH Clinical Intake Team.

To be completed by referring Medical Practitioner

Information for referring Medical Practitioner

Re: _____ **DOB:** _____
Given Name(s) SURNAME

A request has been made for this patient to be assessed by the Centre for Developmental Disability Health. We have asked that the patient be reviewed by you prior to being seen at the CDDH clinic to ensure we have all the information relevant to assessment. Would you please:

1. **Review part A** of this form, particularly in relation to medications and allergies.
2. **Examine** the patient and record your findings on the following page.
3. **Provide referral details**

The CDDH provides advice, support and education for medical practitioners throughout Victoria in relation to the care of their patients with developmental disability. Support includes:

- Telephone advice for doctors
- Clinical assessment of the patient, recommendations for management and a detailed report for the persons treating doctor.
- Referral to other agencies / specialists as part of the assessment process, if indicated, including referral to the CDDH Consultant Psychiatrist for assessment of mental health.

The CDDH is an assessment service only and does not provide primary, emergency, crisis or on-going care.

Note: Medicare: If your patient has an intellectual disability you can use the information in this form as part of your **Annual Health Assessment for a Person with an Intellectual Disability (Item Nos. 701, 703, 705, 707)** consultation. Clinicians at the CDDH can be included in a GP Management Plan 723.

To be completed by referring Medical Practitioner

❖ **Step 1 – Review Part A**

* carefully review the information supplied in PART A of this form and add any other relevant information you may have
* check that information provided regarding medications is correct, then sign and date (page 10)

❖ **Step 2- Examine the patient and record relevant findings**

Height _____ Weight _____ BMI _____

Urine _____ Blood glucose _____

BP _____ Pulse _____

Head & neck _____

Teeth & throat _____

Eyes/ Vision _____

Ears/hearing _____

Heart _____

Chest _____ _____

Abdomen _____

CNS _____

Periphery (including nervous system) _____

Musculoskeletal _____

Skin _____

Breasts/genitalia/prostate _____

Other findings or extra details on any of the above _____

_____

If adequate examination was not possible, please comment.

_____

_____

Please attach any recent relevant investigation results and or specialist assessments.

To be completed by referring Medical Practitioner

<u>Step 3 – Referral:</u> Having reviewed all the information provided and examined the patient:

- **What do you see as the major current issues/concerns in the health care of this patient?**

  _____

  _____

- **How urgent do you feel this problem is?** Urgent ☐ Semi urgent ☐ Non urgent ☐

  Please explain why, if you consider that it is urgent:

  _____

  _____

- **Do you consider an appointment with the CDDH is appropriate?**

  YES ☐ NO ☐

  Would you like phone contact from CDDH to discuss the referral?

  YES ☐ NO ☐

If your patient is taking psychotropic medication, has a psychiatric history, has a behaviour problem, or if dementia is a possible diagnosis, then they may benefit from an assessment by a CDDH psychiatrist. A referral for psychiatric assessment is required for your patient to see a CDDH psychiatrist.

Patients may be seen by an RANZCP accredited psychiatry trainee under the supervision of a CDDH psychiatrist.

If you are you agreeable to a psychiatric evaluation, please refer by ticking this box: ☐

- We are building a registry of GPs who are confident and comfortable with working with people with a disability. Are you willing to have your name put on this registry? YES ☐ NO ☐

- Would you like to receive information on the Centre for Developmental Disability Health, its services and products? YES ☐ NO ☐

To be completed by referring Medical Practitioner

SIGNATURE: _____ **DATE:** _____

PROVIDER No: _____ **Phone No:** _____

Name: _____

Address: _____

Postcode: _____

Fax: _____

E-mail: _____

or Stamp

Thank you for providing this information.

Further information and resources:
Please go to the CDDH website: www.cddh.monashhealth.org for more information about the healthcare of people with intellectual and associated developmental disabilities.