



## Residential Services For Persons With Disabilities

# Head To Toe Assessment

— 2019 —

## My Health Check

Name: \_\_\_\_\_

Date of Health Check: \_\_\_\_\_

*Insert my picture here*

This Health Check was developed by the:  
National Personal Planning Subgroup  
Quality Improvement Team  
HSE Disability Services - Operations

The Health Check is for use in HSE and HSE funded services.

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# My Health Check

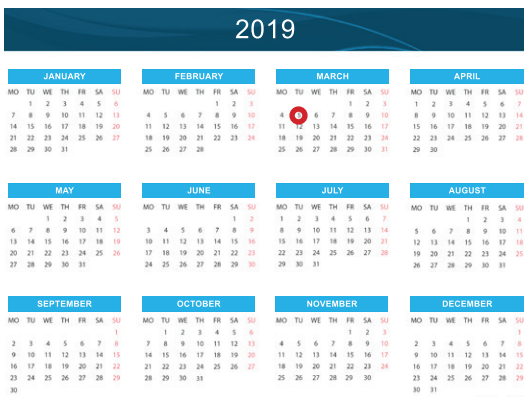
## 1. Having a health check

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Health checks are very important so that we stay healthy.

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We should have a health check once a year.

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This is your health check.

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

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You will be asked to tell us if you have any problems with your health.

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It is very important to keep a record of your health and take care of anything that might be causing you a problem.

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Your records are private and will be kept safe. Only you or your care team will see your record.

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

## 2. My Personal Details:

My name: \_\_\_\_\_ Male/Female (please mark)

My date of birth: \_\_\_\_\_

Unique identifier: \_\_\_\_\_

My address: \_\_\_\_\_

My residential service: \_\_\_\_\_

Date of my health check: \_\_\_\_\_

The name of person completing my assessment with me: \_\_\_\_\_

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

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My GP's (doctor's) name is: \_\_\_\_\_

Name of last GP (if changed in the last year): \_\_\_\_\_

Is there access to my medical records?

Yes

No

If you have a name for your disability please add it here: \_\_\_\_\_

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Additional comments:

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

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

	Yes	No	Don't know
Asthma			
Osteoporosis			
Diabetes			
Epilepsy			
Glaucoma			
Heart problems			
Blood pressure			
Cancer or history of cancer			

I would like to ask you about the immunisations you have had. It is ok if you do not know.

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

Please note the action to be taken from this section:

1. If yes for family history, this needs to be referred to the nurse/public health nurse/practice nurse/GP.
2. If these are unknown, or no, these need to be flagged and undertaken.

In services where there is no nursing access, this form is used to identify gaps for attending the GP.

**\*If dates of vaccinations are unknown please state 'unknown' clearly, do not leave blank\*.**

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

### 5. My feeling about my health

Choose a picture that tells me how you feel about your health?



Awful



Not very good



Good



Really Good



Brilliant

Are there things we can do to help you feel better? Tell us....



**Please list any actions to be taken from this section:**

**The next questions are about your body.**

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

Now I will ask you some questions about your medicines.

7. My medicines	Yes	No
<p>Do you take medicines?</p> <p>This includes what your doctor tells you to take and what you can buy in the shop, for example pain killers, vitamins, cough medicine or other.</p> <p><b>Note to assessor: If no, skip this section.</b></p>		
<p>Has your medicines been reviewed in the last 3 months?</p> <p>Yes <input data-bbox="300 660 443 728" type="checkbox"/> No <input data-bbox="619 660 762 728" type="checkbox"/></p>		
<p><b>Please list any actions to be taken.</b> <b>Ref to guidance doc.</b></p>		

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

8. Allergies
<p>Do you have allergies or are you sensitive to anything like medicines, food, drinks, washing powder or anything else?</p> <p>Yes: <input data-bbox="304 1406 453 1473" type="checkbox"/> No: <input data-bbox="635 1406 783 1473" type="checkbox"/></p> <p><b>Note to assessor: If no skip this section.</b></p>
<p>If yes please tell us...</p>
<p>The cause of your allergy or what you are sensitive to:</p>

The reaction you get: (example rash, swelling)

**Please list any actions to be taken from this section?** NB Ensure medication allergy is indicated on prescription record and hospital passport as appropriate.

### 9. My hair, nails and skin.

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

#### My hair

In the last while, have you noticed anything different about your hair condition?  
For example are you losing any hair, is your scalp itchy or dry?

Yes

No

#### My nails

In the last while, have you noticed any changes in your nails? For example if they break easily, are sore or a different colour to usual?

Yes

No

#### My skin

In the last while, have you noticed any changes to your skin? For example any spots, pimples or lumps you haven't noticed before?

Yes

No

Does your bottom, elbows or heels get sore when you sit for a long time?

Yes

No

Do you bruise easily?

Yes

No

Please note any actions to be taken from this section.

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

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

#### My eye sight

How is your eye sight?



Awful



Not very good



Good



Really Good



Brilliant

Do you have any problems with your eyes? For example do you have sore, itchy, sticky eyes or eyelids?

Yes

No

Can you see things clearly far away from you and near to you? For example, can you see the television clearly or look at a picture or writing in a book?

**Far away:**

Yes

No

**Near:**

Yes

No

Do you ever bump into things because you did not see them as you were walking past?

Yes

No

Do you wear glasses or contact lenses?

Yes  No

---

Have you had an eye test recently?

Yes  No

---

If yes, do you know when that was?

If no, an annual eye test needed. (Red flag for action)

---

Have you had retinal screening?

Yes  No

---






Have you any other problems with your eyes?  
Please tell us.

---

**Please list any actions to be taken from this section.**

**My ears and my hearing**

How is your hearing?

Awful      Not very good      Good      Really Good      Brilliant

---

Do you have any problems with your ears or hearing? For example have you any difficulty hearing what people are saying to you or when you are in a group?

Yes  No

Do you have any problems with wax, soreness, itchy ears or do you need to continuously rub your ears?

Yes  No

Do you get buzzing in your ears?

Yes  No

Do you wear a hearing aid?

Yes  No

Have you had a recent hearing test?

Yes  No

Do you know when that was?

Yes  No

Is there anything else about your ears and hearing that you want to tell us about?

**Please list any actions to be taken from this section.**

### **My mouth, teeth and gums**

Do you have teeth?

All my own

Some of my own

None of my own

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

Yes

No

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

Yes

No

Do your gums bleed when you brush your teeth?

Yes

No

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

Yes

No

Do you go to the dentist regularly?

Yes

No

Do you know when you last went to the dentist?

Date:

\_\_\_\_\_

**Please list any actions to be taken from this section.**

### **My Nose**

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

Yes

No

Do you often get a blocked or runny nose?

Yes

No

Do you have difficult in smelling or tasting things?

Yes

No

**Please list any actions to be taken from this section.**

### My throat

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

Yes

No

Do you have difficulty swallowing?

Yes

No

Do you have any thyroid problems?

Yes

No

Do you feel the cold a lot?

Yes

No

Do you ever get tightness or swelling in your throat?

Yes

No

**Please list any actions to be taken from this section.**



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

**11. My mental and emotional health**

How do you feel in the last 3 months?



Awful



Not very good



Good



Really Good



Brilliant

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

Yes

No

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

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

How well do you sleep in the last 3 months?



Awful



Not very good



Good



Really Good



Brilliant

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

Yes

No

Do you ever have night sweats?

Yes

No

**Please list the actions to be taken from this section.**

**Now I would like to ask you about pain.**

## 12. Pain

Do you often get pain? Like headaches or stomach pains.

Yes

No

If yes, tell us more about your pain.

Have you had a pain assessment?

Yes

No

**Please list the actions to be taken from this section.**

Now I would like to ask you about your memory.

### 13. My Memory

Do you often forget where you put things?

Yes  No

Do you often forget the names of people you know well?

Yes  No

Have you ever seen a doctor about your memory?

Yes  No

Have you ever had a memory assessment?

Yes  No

**Please list the actions to be taken from this section.**

**Note to assessor:** \*Indications for doing a baseline screening dementia assessment:

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

Now I would like to ask about epilepsy.

### 14. Epilepsy

Do you have epilepsy? (seizures)

Yes  No

**Note to assessor: if no, skip this section.**

If yes, have you had a specialist assessment?

Yes  No

<p>When did you have your last seizure?</p> <p>Date: _____</p>
<p>When were you last seen about your epilepsy?</p> <p>Date: _____</p>
<p>Who did you see? Was it a clinical nurse specialist, doctor, neurologist; Please tell us.</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Do you have a support plan to help you with your epilepsy?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no, a support plan is needed.</p>
<p><b>Please list the actions to be taken from this section.</b></p>

**15. My breathing and circulation**

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

<p><b>My breathing</b></p>
<p>Do you have any problems with your breathing, for example do you get breathless when walking?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Do you have a chronic breathing condition (something you have had for a while, for example asthma)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Please list the actions to be taken from this section.

### My circulation

Do you have?

High blood pressure

Yes

No

Low blood pressure

Yes

No

What is your usual blood pressure (BP)? \_\_\_\_\_

When was your blood pressure checked last? \_\_\_\_\_

What is your pulse rate, blood pressure at rest?

Pulse

Blood pressure

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

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

Yes

No

Do you have bulging or varicose veins on your legs?

Yes

No

Have you had your cholesterol level checked?

Yes

No

When was your cholesterol checked last?

Date: \_\_\_\_\_

**Please list the actions to be taken from this section.**

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

### 16. My digestion

Do you have a problem with your digestion for example heartburn or indigestion?

Yes

No

Do you have a chronic digestive condition for example coeliac or crohns?

Yes

No

Do you have any problems eating or swallowing your food and/or drinks?

Yes

No

### **My bowel health**

**Yes**

**No**

Do you have regular bowel movements?

Do you ever get constipated?

Do you get any discomfort, pain or bloating in your stomach?

Do you ever bleed from your back passage after going to the toilet?

Do you have piles?

Have you ever had a bowel screen?

If yes, date: \_\_\_\_\_

Please list the actions to be taken from this section

## 17. Female health

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

### Some private questions about your female health

Have you any problems with your breasts for example lumps, bumps or spots?

Yes

No

Do you check your breasts regularly?

Yes

No

Have you had a breast check?

If yes, date: \_\_\_\_\_

Do you have regular periods?

Yes

No

Have your periods changed recently for example lighter or heavier?

Yes

No

Have you started the menopause yet?

Yes

No

If yes are you on medicines for this?

Yes

No

Have you had a cervical smear?

Yes

No

If yes, date \_\_\_\_\_

Do you ever get itching, discomfort or unusual discharge from your private parts?

Yes  No

Are you in a relationship?

Yes  No

**Please list the actions to be taken from this section.**

### 18. Male Health

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

#### Some private questions about your male health

Do you have any problems with your private areas for example swelling, soreness or discharge?

Yes  No

Do you have a prostate problem for example difficulty passing urine or slow to start, can't go sometimes, or dribbling?

Yes  No

Have you had a blood test for your prostate recently?

Yes  No

If yes, date: \_\_\_\_\_

Have you seen a doctor about your private area recently?

Yes  No

If yes, date: \_\_\_\_\_



Do you ever have problems with itching, or unusual discharge in your private areas?

Yes

No

Are you in a relationship? Yes  No

**Please list the actions to be taken from this section.**

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

### 19. My urinary health

Do you have any problems with passing urine for example pain or stinging or burning?

Yes

No

Have you noticed any unusual smell from your urine or an unusual colour?

Yes

No

Do you have any problems staying dry during the day?

Yes

No

Do you have any problems staying dry during the night?

Yes

No

Have you had a continence assessment recently?

Yes  No

If yes, date: \_\_\_\_\_

**Please list the actions to be taken from this section.**

## 20. Mobility, Bones, Joints and Feet

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

### My mobility

Do you need supports with your mobility for example do you need assistance with moving around safely or getting up from a chair or bed?

Yes  No

Do you use anything to help you move around like a stick, scooter or wheelchair?

Yes  No

If yes, what do you use? \_\_\_\_\_

Do you use a hoist?

Yes  No

Do you ever get pain when you are moving about for example getting up from a chair or bed?

Yes  No

Do you have any problems with your back, for example, pain or difficulty standing up straight?

Yes  No

Have you had a fall in the last 6 months?

Yes

No

Are you afraid you might fall?

Yes

No

Have you had a falls assessment recently?

Yes

No

If yes, date: \_\_\_\_\_

Have you seen anyone recently about your mobility, for example, a doctor or physiotherapist?

Yes

No

If yes, date: \_\_\_\_\_

**Please list the actions to be taken from this section.**

### **My bones and joints**

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

Yes

No

Have you osteoporosis (brittle bones)?

Yes

No

Have you broken any bones recently?

Yes

No

Have you had a DXA (bone) scan?

Yes

No

If yes, date: \_\_\_\_\_

**Are you taking any of these medicines?**

**Yes**

**No**

Anti – epileptic medicines

Medicines for your mental health

Medicines for your stomach

**Please list the actions to be taken from this section.**

## My feet

Do you have any problems with your feet? For example ingrown toe nail, corns or bunions?

Yes  No

Do you have any pain in your feet or toes?

Yes  No

Do you ever have very cold feet?

Yes  No

Do you have diabetes?

Yes  No

Have you had a foot assessment?

Yes  No

Have you seen a chiropodist recently?

Yes  No

If yes, date \_\_\_\_\_

**Please list the actions to be taken from this section.**

## 21. Summary

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

<b>Section</b>	<b>Action to be taken: Yes or No</b>
Personal details	
Family's health	
Immunisations	
Body	
Medicines	
Allergies	
Feelings about my health	
Hair	
Nails	
Skin	
Eyesight	
Ears and my hearing	
Mouth, teeth and gums	
Nose	
Throat	
Mental and emotional health	
Pain	
Memory	
Epilepsy	
Breathing	
Circulation	
Digestion	
Female health	
Male health	
Urinary health	
Mobility	
Bones and joints	
Feet	

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

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

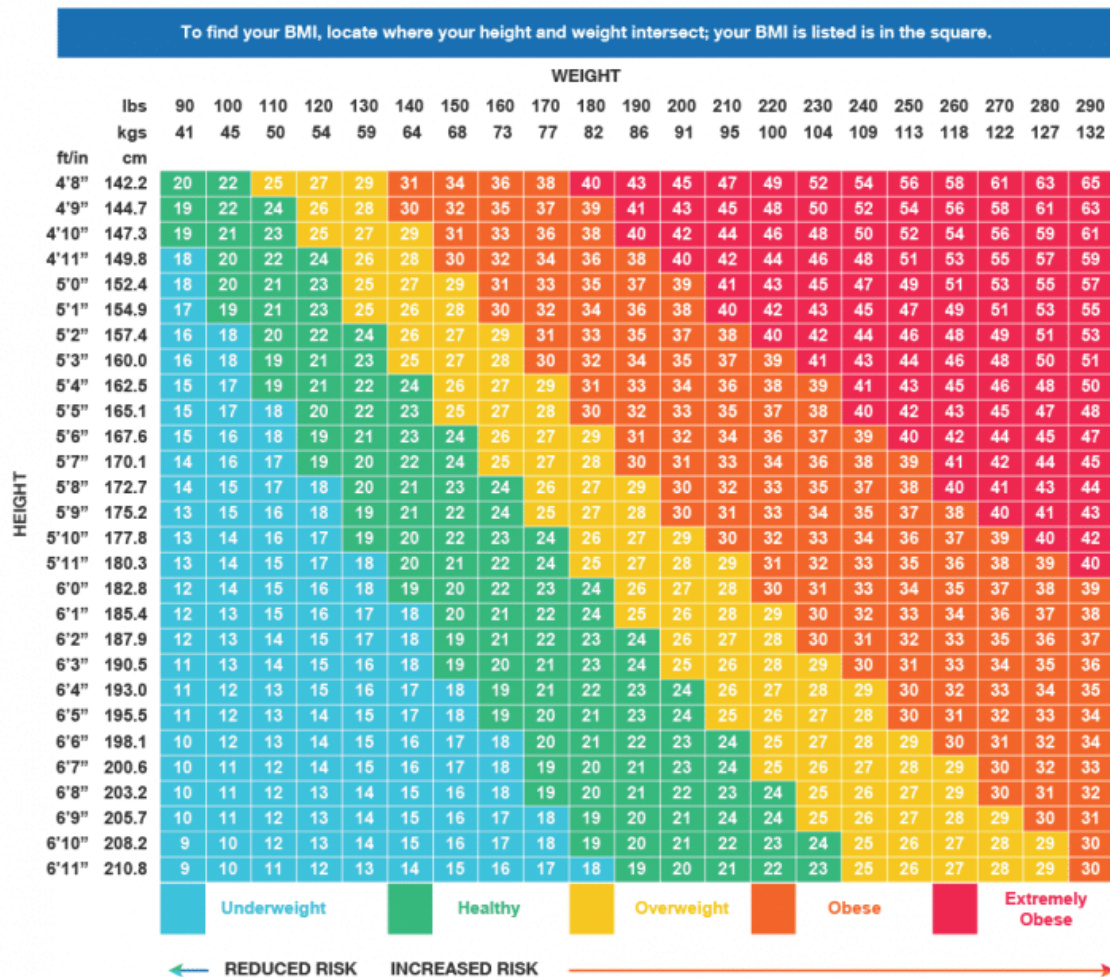
Source: NHLBI Obesity Education Initiative (2000)

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

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

M, men; W, women

## Appendix 2 Calculating BMI



<https://bmiccalculatorireland.com>

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

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

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



# **Guidance document to support head to toe assessment**

**May 2019**

## Introduction

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

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

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

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

## 1. Having my health check

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

## 2. Your personal details

This section to be completed in full.

## 3. Your family's history

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

## 4. Your immunisation history


If dates of vaccines are unknown, please state 'unknown' clearly - DO NOT LEAVE BLANK.

Consult GP

[www.immunisations.ie](http://www.immunisations.ie)

## 5. Your feelings about my health



Using the faces  as a guide if person responds 'not very good' or 'awful' –please report to nurse/public health nurse/practice nurse/GP/house parent/team leader/social care worker/family member.

Advocacy is also advisable. Advocacy services may support the person around health matters

List of Advocacy Services available at:

<https://www.hse.ie/eng/about/qavd/complaints/ysysguidance/appendices/advocacy%20services.docx>

Local advocacy groups may also be available.

## 6. My body

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

Irrespective of height, a waist measurement of greater than 37 inches (94cm) for men or 32 inches (80cm) for women is an indicator of increased health risk.

(SAFEFOOD.EU)

Stop the Spread campaign.

<https://www.icgp.ie/go/library/catalogue/item/DF2B8347-BCBE-4C31-94546BC305B29780>

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

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

The people with moderate intellectual disabilities or the more high functioning individuals tend to be at higher risk of becoming overweight/obese. Again weight checks are necessary here to monitor their weights and referral to a Dietitian/GP for support with a weight loss/healthy eating plan is needed.

<https://www.hse.ie/eng/staff/pcrs/online-services/musttool.pdf>

## 7. Your medicines

HIQA Standard re: medicines

Multidisciplinary Annual Review should include a review of their medications.

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

Refer to local policy for medication reviews.

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

## 8. Your allergy history

This section to be completed in full –any allergy to be brought to the attention of nurse/public health nurse/practice nurse/GP/house parent/team leader/social care worker/family member. If allergic to any medication – needs to be highlighted on medication prescription and administration record, risk assessment, hospital passport and support plan must be in place.

Ensure allergies are highlighted according to service policy.

## 9. Your hair, nails and skin

### Hair

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

### Nails

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

### Skin

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

## 10. Your eyes, ears mouth, nose and throat

### Your eyesight

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

### Your ears and my hearing

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

#### Note:

Every 3 years for persons with Down Syndrome (WHO)

Person with Hearing aids may require more frequent hearing test.

<https://www.hse.ie/eng/services/list/4/audiology/community-audiology/>

### Your mouth teeth and gums

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

**Recommendation:**

Annual check-up with Dentist  
Dental Hygienist every 6 months

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

<https://health.gov.ie/wp-content/uploads/2019/04/NOHP-Main-FINAL.pdf>

(2019)

**Your nose**

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

**Your throat**

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

## 11. Your mental and emotional health



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

Insert NICE guidelines here.

Sleeping pattern record may be considered.

## 12. Pain

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

Pain assessment tools available at:

<http://hospicefoundation.ie/wp-content/uploads/2016/11/Final-Guidance-Document-5-Pain.pdf>

## 13. Your memory

If responses indicate memory loss please refer to nurse/public health nurse/practice nurse/GP.

Recommendation:

Indications for doing a baseline screening dementia assessment:

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

## 14. Epilepsy

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

If no epilepsy skip this section.

Please note:

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

## 15. Your breathing and circulation

### **Your breathing**

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

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

Vaccinations for influenza and pneumococcus are up to date

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

### **Your circulation**

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

Recommendation;

Any person with an intellectual disability and over 40 years who is assessed to be at high risk of Cardio Vascular Disease should be offered a Cardiovascular risk assessment or health check. This will include;

Measurement of height weight and blood pressure  
Cholesterol and sugar blood profile  
Family history, medication, diet and levels of physical activity (Taggart, 2014).

## 16. Your digestion

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

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

## 17. Your female health

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

Register for Breast check: 50 - 69 years  
Register for Cervical check: 25 - 60 years  
Register for Bowel check: 60 - 69 years  
Register for Diabetic Retinal Screening (must have a diagnosis of Diabetes)

[www.screeningservice.ie](http://www.screeningservice.ie)

## 18. Your male health

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

Register for Bowel Check: 60 - 69 years  
Register for Diabetic Retinal Screening (must have a diagnosis of Diabetes)  
General advice on Prostatic symptoms – discretion of GP.

[www.screeningservice.ie](http://www.screeningservice.ie)



## 19. Your urinary health

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

Consider a baseline continence assessment if appropriate.

Sample assessment available from HSE website at:

<https://www.google.com/search?q=continence+assessment+form+hse&oq=continence+assessment+&ags=chrome.2.69i57j0j69i59j0l3.6387j0j4&sourceid=chrome&ie=UTF-8>

## 20. Your mobility

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

Consider a mobility assessment if appropriate

Assessments available at

<https://www.hse.ie/eng/staff/safetywellbeing/healthsafetyand%20wellbeing/manualhandlingandpeoplehandlingpolicy.pdf>

Bone Density assessment (DXA)

<https://www.hse.ie/eng/health/az/b/bone-densitometry-scan/>

### **For persons with Downs syndrome**

If a person with Down syndrome develops any of the Red Flags/Warning Signs below:

#### Red Flags/Warning Signs:

- Neck pain, or pain behind the ear
- Abnormal head posture
- Torticollis (Wry neck)
- Reduced active neck movements
- Deterioration of gait and/or frequent falls
- Increasing fatigability on walking
- Deterioration of manipulative skills
- Loss of bowel and/or bladder function

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

## 21. Your bones and joints

Risk Factors will determine requirement for bone density testing

- Loss in height 2-16cm.

It is not normal at any age to suddenly lose height. Height loss of >2 inches is an important sign of an asymptomatic vertebral fracture and such persons should be evaluated for osteoporosis.

A person can lose height due to wear and tear of vertebrae and/or disc but >2 inches is unusual in degenerative joint and disc disease. (ICGP, 2011)

if you are taking any of the following:

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

Consult your GP

## 22. Your feet

Consider Brunswick foot assessment if appropriate

<https://www.gnb.ca/0053/phc/pdf/2015/10078e.pdf>

Foot care and chiropody services check:

<https://www.hse.ie/eng/services/list/4/olderpeople/tipsforhealthyliving/footcare.html>

## Resources

General

<http://www.intellectualdisability.info/>

[www.easyhealth.org.uk](http://www.easyhealth.org.uk)

[www.inclusionireland.ie](http://www.inclusionireland.ie)

<https://idstilda.tcd.ie/>

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

[http://www.speakup.org.uk/?page\\_id=1412](http://www.speakup.org.uk/?page_id=1412)

Breastcheck

[https://www.breastcheck.ie/content/news/breastcheck\\_develops\\_manual\\_for\\_women\\_with\\_intellectual\\_disabilities](https://www.breastcheck.ie/content/news/breastcheck_develops_manual_for_women_with_intellectual_disabilities)

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

Cervicalcheck

<https://www.cervicalcheck.ie/fileupload/File/Guide%20for%20Smear%20takers%20Jan%2009/Chapter%206%20Womens%20Participation.pdf>



