



# Annual Health Assessment for People with Intellectual Disability

## ADULT

**Name of the Person** (having the assessment)

This document is reviewed annually and updated as appropriate to be consistent with current relevant evidence and national and international guidelines. Check the Department of Health and Aged Care website for the latest version of this document.

For more information and resources on annual health assessments for people with intellectual disability visit [www.health.gov.au/ahas](http://www.health.gov.au/ahas) or email [Intellectualdisability@health.gov.au](mailto:Intellectualdisability@health.gov.au)

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## People supporting the annual health assessment

Name of Family Member / Carer / Support Worker

Name of General Practitioner (GP)

### Steps to follow

1. You (the person with an intellectual disability), a family member and/or support staff fill in **Part 1** of this book. It is OK to get information from records, family members and staff.
2. Make a long appointment with your usual GP.
  - Ask the receptionist if the clinic has a Practice Nurse, as they may be able to assist with the health assessment.
  - You may wish to book the first appointment of the day to avoid long waiting times.
3. Take this book to the appointment with the GP and/or email it to your GP before the appointment.
4. The GP will look through the first part of this book and fill in **Part 2** while examining you.
5. It is important that the Action Plan is filled in at the end of the consultation. A copy of the Action Plan is to be kept with your personal record.
6. Medicare supports this ANNUAL health assessment. Please refer to Page 19 for details of Medicare items.

People with intellectual disability generally have poor health. Their healthcare is generally of a lower standard. The Comprehensive Health Assessment Program (CHAP) was designed to improve the interaction between the GP and the person with intellectual disability.

It does this by:

- recording a dedicated health history from you and/or your carer
- improving communication between, and integration of, disability and health services
- educating and empowering all those involved in the health assessment
- providing guidelines for the GP on commonly missed health issues for this population.

Use of the CHAP can improve your health. Research (including several randomised controlled trials) has demonstrated its benefit in detecting new disease, and enhancing health screening and promotion.

## Part 1

To be completed by you, your family and/or support staff.

Tick the boxes below if you have experienced any of the following signs and symptoms in the **last year**.

If you are unsure or don't know the answer, please tick the 'unsure/don't know' box.

To make an accurate medical assessment of your health, the doctor needs to know about these signs and symptoms.

	Yes	No	Unsure/ don't know
<b>1. Breathing</b>			
Do you <b>cough</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough up <b>blood</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a <b>runny</b> nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you cough up <b>stuff/mucous/sputum</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of <b>breath</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you <b>wheeze</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Heart</b>			
Do you have a <b>heart disease</b> that you have had from birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>chest pain</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your heart 'race'/ <b>beat quickly</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your <b>ankles swell</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get <b>short of breath</b> while lying in bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get a <b>blue tinge to your skin</b> (for example, fingers/lips/toes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Muscles &amp; Joints</b>			
Do you have <b>joint pain or back pain</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>muscle pain or weakness</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use <b>walking aids or orthotics</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>scoliosis</b> (curved or twisted backbone) <b>or contractures</b> (painful tight muscles)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Stomach/Bowel</b>			
Have you <b>lost weight</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>trouble swallowing</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you <b>regurgitate/vomit</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get <b>heartburn</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>diarrhoea</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>black bowel motions/faeces/poo</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get <b>constipated</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose control of <b>bowel motions</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>abdominal/stomach pain</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Unsure/  
don't  
know

Yes

No

### 5. Urinary system

	Yes	No	Unsure/ don't know
Do you have <b>pain</b> when passing <b>urine/wee</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>blood</b> in your <b>urine</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you <b>lose control</b> of your <b>urine</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you take care of your <b>toileting needs</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you <b>urinate more</b> than in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 6. Nervous system

Questions about epileptic episodes (fits) are covered in section 13.

Do you <b>have headaches</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you <b>faint</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get <b>unsteady</b> when walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do your arms or legs become <b>weak</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <b>tingling</b> or strange feelings in your skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 7. Skin

Do you have <b>any skin disease or rash</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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### 8. Pain perception

How do you react to pain?

How do you communicate pain?

### 9. Medications

It is important for the doctor to know about ALL your medication.

List the medication/s prescribed by any doctor.

Name	How often and how much is taken?	When was it first prescribed?
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY
		DD / MM / YYYY

When were medications last reviewed?

Who reviewed the medications?

List any medications bought 'over the counter' without a script, including alternative health remedies.

Name	How often and how much is taken?

### 10. Allergies

List anything you are allergic to, including medications.

What are you allergic to?

### 11. Sleep

Do you experience any problems with <b>sleeping</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please describe			

### 12. Cause of intellectual disability

Is the cause of your intellectual disability known?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please give details			

### 13. Epilepsy

Have you ever had epileptic seizures/fits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>No</b> or <b>Unsure</b> , please go to <b>question 14</b>			
If <b>Yes</b> , please describe and list the <b>type, number</b> and <b>usual duration</b> of seizures during the last year.			

Type of seizures	Number	Usual duration

Which doctor treats the epileptic seizures/fits?	Please tick one
GP	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>
Other Please describe	<input type="checkbox"/>

**Epilepsy – Continued**

<b>When did this doctor last review your epilepsy?</b>	
Month and year if known <input type="text" value="MM/YYYY"/>	
Unknown <input type="checkbox"/>	
Since this review, have the seizures	<b>Please tick as applicable</b>
Become more severe?	<input type="checkbox"/>
Become more frequent?	<input type="checkbox"/>
Remained the same?	<input type="checkbox"/>
Improved?	<input type="checkbox"/>
Do you have an Epilepsy Management Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**14. Sexual orientation and gender identity**

<b>What is your gender identity?</b>	<b>Please tick one</b>
Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Non-binary	<input type="checkbox"/>
Other	<input type="checkbox"/>
I do not want to answer	<input type="checkbox"/>

<b>What sex was originally listed on your birth certificate?</b>	<b>Please tick one</b>
Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Other Please describe	<input type="checkbox"/>

<b>Do you identify as</b>	<b>Please tick as applicable</b>
Straight or heterosexual	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>
Lesbian or gay	<input type="checkbox"/>
Other	<input type="checkbox"/>
I do not want to answer	<input type="checkbox"/>



### 15. Relationships

The information you provide must be kept confidential.

You do not have to answer these questions if they make you uncomfortable, but it is very important you tell your GP about any concerns you have.

Have you ever been sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been abused (sexual, physical or psychological)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments			

**For men and people with a penis, please go to question 17**

### 16. Health of women and people with a cervix

Do you have menstrual periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , date of last period <input type="text" value="DD/MM/YYYY"/>			
Unknown <input type="checkbox"/>			
Do you care for your periods yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use Implanon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use an IUD (intrauterine device)? Sometimes these are called 'Mirena' or 'Kyleena'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take the oral contraceptive pill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , what is the name of the pill?			
Do you use any other contraceptive method?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please describe:			

Do you have any of the following:			
Pre-Menstrual Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful periods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal irritation (for example, thrush)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal symptoms (for example, hot flushes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Women and people with a cervix with intellectual disability have the same reason for needing cervical screening as those in the general population. It is recommended for both human papillomavirus (HPV) vaccinated and unvaccinated people, that an HPV test should be performed every five years starting at 25 years of age regardless of sexual orientation.

Continued

Since 1 July 2022, all people can be offered a choice of HPV testing either through a self-collected vaginal sample at the person's general practice or a clinician-collected sample from the cervix.

Taking a self-collected vaginal sample may be assisted by a GP, if necessary, or if the GP is confident a good sample can be collected, it can be taken by the person in a private place without assistance. This change is likely to make cervical screening accessible to more people with disability.

	Yes	No	Unsure/ don't know
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**Health of women and people with a cervix – Continued**

Have you had an HPV test?  If <b>Yes</b> , date of last test <input type="text" value="DD/MM/YYYY"/> Unknown <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a cervical screening?  If <b>Yes</b> , date of last screening <input type="text" value="DD/MM/YYYY"/> Unknown <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you need cervical screening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If screening is needed but has not happened, please indicate why:

Distress about the procedure	<input type="checkbox"/>
Screening planned	<input type="checkbox"/>
Desensitisation/preparation planned	<input type="checkbox"/>
Desensitisation/preparation in progress	<input type="checkbox"/>
Other	<input type="checkbox"/>

A mammogram should be arranged every 2 years for women and people with a cervix who are over 50 years of age, or more regularly for people with a family history of breast/ovarian cancer, or Ashkenazi Jewish ancestry.

Are your breasts checked by a GP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a mammogram?  If <b>Yes</b> , date of last mammogram <input type="text" value="DD/MM/YYYY"/> Unknown <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If a mammogram is needed but has not happened, please indicate why:

Distress about the procedure	<input type="checkbox"/>
Mammogram planned	<input type="checkbox"/>
Desensitisation/preparation planned	<input type="checkbox"/>
Desensitisation/preparation in progress	<input type="checkbox"/>
Other	<input type="checkbox"/>

**For women and people with a cervix, please go to question 18**

Yes	No	Unsure/ don't know
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**17. Health of men and people with a penis**

Do you have any problems with your penis (for example, sores, scars or discharge)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are both of your testes in the scrotum?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any erection dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**The remaining questions are for everyone**

**18. Behaviours of concern**

Do you have any behaviours of concern?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If <b>Yes</b>, please describe the behaviours, any consequence (legal or otherwise), and any help you receive for these behaviours:</p>			

**19. Mental health**

Do you have any mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If <b>Yes</b>, please describe the mental health problem/s and any help you receive for the problem/s.</p>			

## 20. Seeing

Do you have a known problem with seeing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please describe the problem.			
If <b>No</b> or <b>Unsure/don't know</b>			
Are you or other people concerned you have a problem with seeing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been prescribed glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , do you usually wear the glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When was the last vision test?			
Month and year if known <input type="text" value="MM / YYYY"/>			
Unknown <input type="checkbox"/>			
Never <input type="checkbox"/>			

Who performed this test?	Please tick one
Eye doctor / ophthalmologist	<input type="checkbox"/>
Optometrist	<input type="checkbox"/>
GP	<input type="checkbox"/>
Test while at school	<input type="checkbox"/>
Unknown	<input type="checkbox"/>

Result of last vision test	Please tick one
Normal	<input type="checkbox"/>
Unknown	<input type="checkbox"/>
Abnormality found	<input type="checkbox"/>
If an abnormality was found, please describe	

**21. Hearing**

Do you have a known problem with hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , please describe the problem.			
If <b>No</b> or <b>Unsure/don't know</b>			
Are you or other people concerned you have a problem with hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been prescribed a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , do you usually wear the hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any other hearing device?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When was your last hearing test?			
Month and year if known <input type="text" value="MM / YYYY"/>			
Unknown <input type="checkbox"/>			
Never <input type="checkbox"/>			

Who performed this test?	Please tick one
Audiologist	<input type="checkbox"/>
GP	<input type="checkbox"/>
Other	<input type="checkbox"/>

Result of last hearing test	Please tick one
Normal	<input type="checkbox"/>
Unknown	<input type="checkbox"/>
Abnormality found	<input type="checkbox"/>

If an abnormality was found, please describe.

## 22. Health promotion & screening

### Dental

Date of last review

Unknown

### Blood pressure

Date of last check

Unknown

### Cigarettes smoked (per day)

### Alcohol (standard drinks per week)

### Recreational drugs (list any used)

### Thyroid function test (TFT)

If you have Down syndrome, when was the most recent test?

Unknown

### Vitamin D test

*Vitamin D deficiency appears to be quite common in people with intellectual disability.*

Date of last review

Unknown

### Bowel cancer test

*Current guidelines recommend that people aged 45 years and over should complete a bowel cancer screening test known as a Faecal Occult Blood Test every two years. People may also need a bowel cancer assessment if they have a family history of bowel cancer, a personal history of inflammatory bowel disease, or symptoms of bowel cancer or with high-risk familial syndromes, such as Lynch syndrome or familial polyposis.*

Date of test

Unknown

### Diabetes test

Date of test

Unknown

### Skin check

Date of last review

Unknown

### 23. Activity & lifestyle

Have you noticed any mobility changes over time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any decline in your abilities, (for example, memory, dealing with money, making meals)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you physically active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any abnormal eating behaviours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there concerns about the quality of your diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inactivity and poor diet can lead to significant health problems and depression.</b>			

### 24. Immunisations

Fill in the following about your immunisations. Are these immunisations up to date?

Ask your GP if there are any immunisations you should get, either as a booster or for the first time.

<b>COVID-19</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , date/s of last immunisation/s			
<input type="text" value="DD/MM/YYYY"/> <input type="text" value="DD/MM/YYYY"/> <input type="text" value="DD/MM/YYYY"/>			
If <b>No</b> , reason why			
<b>Influenza</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , date of most recent immunisation			
<input type="text" value="DD/MM/YYYY"/>			
If <b>No</b> , reason why			
<b>Tetanus/Diphtheria/Pertussis (Whooping Cough)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , date of most recent immunisation			
<input type="text" value="DD/MM/YYYY"/>			
If <b>No</b> , reason why			
<b>Hepatitis A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> , date of most recent immunisation			
<input type="text" value="DD/MM/YYYY"/>			
If <b>No</b> , reason why			

**Immunisations – continued**

<p><b>Hepatitis B</b></p> <p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Pneumococcus</b></p> <p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Meningococcal Meningitis</b></p> <p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Measles, Mumps and Rubella</b></p> <p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>HPV (Human Papilloma Virus)</b></p> <p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Yes	No	Unsure/ don't know
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**Immunisations – continued**

<b>Shingles/Herpes Zoster</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If <b>Yes</b>, date of most recent immunisation</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-bottom: 5px;">DD / MM / YYYY</div> <p>If <b>No</b>, reason why</p>			

**25. Family medical history**

Has anyone in your family (blood relation) had any of the following conditions?	Yes	No	Unsure/ don't know
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**26. Your medical history**

List any information about your health history that has not been recorded in this booklet. Include any medical problems, surgery/operations, gynaecological, obstetric and mental health problems.

**27. Summary of health concerns**

List the concerns you, your family and/or carers have about your health.

**28. Person who completed Part 1 of this document**

Name

Date completed

DD / MM / YYYY

**Remember!**

*If the clinic has a Practice Nurse, speak with them about completing this assessment as they may be able to assist.  
This will make the consultation with the GP easier.*



## Part 2

To be completed by the General Practitioner.

Thank you for reviewing this person's health care.

Date of visit

**Please review the history provided in the Part 1 of this document.**

**Common health deficits for people with intellectual disability include:**

- unrecognised pain or infections
- poor dental care
- over-use and inadequate review of anti-psychotics/anti-convulsants
- unrecognised mental disorder/s, poor psychiatric assessment / management
- inadequate epilepsy assessment / management
- unrecognised / poorly managed constipation
- unrecognised / poorly managed dysphagia and aspiration
- unrecognised reflux esophagitis / H. pylori infection
- unrecognised or poorly managed hearing and vision impairment ± pathology
- incomplete immunisation schedules
- incomplete health screens – BP, skin, breast, cervical
- unrecognised osteoporosis and Vitamin D deficiency
- unrecognised or poorly managed obesity / malnutrition
- undescended testes / hypogonadism
- inadequate information about menstrual management
- inadequate information about human relations and sexuality
- uninvestigated cause of intellectual disability.

**The Medicare Benefits Schedule items for Health Assessments provided for people with an intellectual disability are:**

- 701 (brief)
- 703 (standard)
- 705 (long) or
- 707 (prolonged)

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

**The Chronic Disease Care Management items are:**

- GP Management Plan (item 721)
- Team Care Arrangements (item 723)

**Please perform a COMPREHENSIVE REVIEW of your patient's health:**

- full physical examination
- vision and hearing screening
- urine analysis
- other tests you feel are indicated.

**Please record your findings on the following pages.**

There is syndrome specific information for you to keep at the end of this booklet.

Using this Comprehensive Health Assessment Program (CHAP) can improve the health of a person with intellectual disability. Several randomised controlled trials and observational studies have demonstrated its beneficial effect to detect new disease, and enhance health screening and promotion. This information is updated on an annual basis in line with current evidence and national and international guidelines.

**1. Check**

Height	<input type="text"/>	cm
Weight	<input type="text"/>	kg
Waist measurement (if necessary)	<input type="text"/>	cm
Blood Pressure	<input type="text"/>	mmHg
Pulse Rate	<input type="text"/>	BPM

If the person has a weight / blood pressure problem, please specify action recommended or taken:

Weight control	<input type="text"/>
Hypertension	<input type="text"/>

**2. Systems check**

*Please perform a complete comprehensive physical examination*

	New findings
Cardiovascular	<input type="text"/>
Respiratory	<input type="text"/>
Musculo-skeletal	<input type="text"/>
Renal / urogenital	<input type="text"/>
Endocrine	<input type="text"/>
Gastrointestinal	<input type="text"/>
Nervous	<input type="text"/>
Skin	<input type="text"/>

**3. Mental health problems**

*Common problems are adjustment to transitions / grief, risk of neglect / abuse, anxiety disorders, mood disorders (for example, depression), emerging psychosis.*

Is there any evidence of a mental health problem?      Yes  No

If **Yes**, please describe.

Is there any evidence of self harm, suicidal thought or thoughts of harming others?      Yes  No

If **Yes**, please describe.

#### 4. Epilepsy

*If present*

- Has the person's seizure control been reviewed? Yes  No
- Does the person have an epilepsy management plan? Yes  No
- Has the risk of SUDEP been minimised? Yes  No
- Has a referral been considered? Yes  No

#### 5. Vision test

*For those who cannot name letters, please use the last page to aid testing*

- Has the person's vision been tested? Yes  No

Test result (corrected)

- Both eyes  Right  Left
- Unable to test  Uncertain

*If abnormal, unable to test or uncertain, consider referral.*

#### 6. Hearing test

*Appropriate hearing test: Whisper test both sides at 0.6 metre with aids if used*

- Has a hearing test been performed? Yes  No

Test result

- Right ear  Left ear
- Unable to test  Uncertain

*If abnormal, unable to test or uncertain, consider referral.*

- Has an otoscopy been performed? Yes  No

*If hearing test or otoscopy abnormal, unable to test or uncertain, consider referral.*

#### 7. Aetiology

*If there is no definitive diagnosis and the tests below have not been performed*

Discuss genetic testing covering the potentials advantages and disadvantages of pursuing an underlying genetic diagnosis

- advantages: support groups, assist NDIS funding, reproductive confidence, an explanation, link to specific management guidelines
- disadvantages (occasionally): currently limited treatments, adjustment to a diagnosis, chance of test being non diagnostic and giving uncertain or incidental findings.

---

Recommend a chromosome microarray AND Fragile X PCR (Medicare indication: Intellectual disability).

If regression of skills or multi-organ involvement, order a urinary metabolic screen.

---

If there is an underlying genetic cause identified, then discuss if the person would like a referral to a genetic counsellor to help them understand their genetic condition and what this means for their care and family planning.

---

#### 8. Sleep

- Does the person have sleep apnoea or sleep problems? Yes  No

## 9. Health of women and people with a cervix

Was a breast examination undertaken? Yes  No

Is a mammogram required? Yes  No

Was cervical screening undertaken/organised for the future (for example, Supporting vaginal swab for HPV)? Yes  No

*If the person has symptoms which could be suspicious for cervical cancer a co-test rather than a screening test should be ordered alongside other investigations as appropriate.*

## 10. Health of men and people with a penis

Was the person checked for undescended testicles? Yes  No

Does this person need prostate screening? Yes  No

## 11. Sexual and reproductive health

*Recommend a review of their reproductive health, sexual activity and sexual development.*

## 12. Abuse and trauma

*Check for signs of physical, psychological or sexual abuse and trauma.*

## 13. Dental health

Is there obvious dental pathology? Yes  No

Has the person been reviewed by a dentist in the last six months? Yes  No

Does the person need a dental assessment? Yes  No

## 14. GIT and bladder function

*Especially for people with cerebral palsy*

Has the person been assessed for dysphagia? Yes  No

Has the person been assessed for gastro-oesophageal disease? Yes  No

Does the person experience urinary or bowel incontinence? Yes  No

Does the person have chronic constipation? Yes  No

## 15. Activity and lifestyle

*Inactivity and poor diet can lead to significant health problems and depression*

Does the person have sufficient **exercise**? Yes  No

Does the person have any **diet problems / abnormal eating behaviours**? Yes  No

Is a referral needed for any of these? Yes  No

## 16. Health promotion and screening

Blood glucose tested? Yes  No

Lipid Screen tested? Yes  No

Thyroid function tested? Yes  No

*Especially in people with Down syndrome*

Colorectal cancer assessment? Yes  No

*Same risk factors as general population*

Osteoporosis risk assessed? Yes  No

*Vitamin D deficiency, poor diet, lack of exercise, hypogonadism and medication (including anti-psychotics & anti-convulsants) issues all appear to be common in some people with intellectual disability.*

## 17. Immunisations

If indicated, are the following up to date?

COVID-19	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Influenza	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tetanus, diphtheria & pertussis (dTpa)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis A	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pneumococcus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Meningococcal	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Measles, Mumps & Rubella	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Human papillomavirus	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Herpes Zoster	Yes <input type="checkbox"/>	No <input type="checkbox"/>

For more details, please refer to *The Australian Immunisation Handbook*:

<https://immunisationhandbook.health.gov.au/>

## 18. Medication review

Including prescription and non-prescription medications

Have the person's medications been reviewed? Yes  No

Have you communicated indications, side effects and interactions? Yes  No

## 19. Future planning

Have there been any **mobility** changes over time? Yes  No

Has there been any **functional decline** over time? Yes  No

Would you be surprised if the person were to die in the next 12 months? Yes  No

If **No**, have you considered **advanced care planning and palliative care**, and discussed with the person, their family or carers? Yes  No

---

If possible, please assist the person, carer or support worker to complete the 'ACTION PLAN' on the following page. A copy of the ACTION PLAN can be given to the person and their care provider. This book can be returned to the care provider who came to this consultation.

Thank you for your comprehensive health review of this person. Your efforts are part of improving the poor health status of the 400,000+ Australians with intellectual disability.

**Based on this, you can make a further appointment to do a formal management plan.**

The Medicare Benefits Schedule items for Health Assessments provided for people with an intellectual disability are:

- 701 (brief)
- 703 (standard)
- 705 (long) or
- 707 (prolonged).

The Chronic Disease Care Management items are:

- GP Management Plan (item 721)
- Team Care Arrangements (item 723)

**Thank you for your assistance.**

---

Name of person

Address

## ACTION PLAN

### What actions to do next and by whom

<b>Problem(s) identified</b>	<b>Action(s) to be taken, including medication changes</b> (for medication changes, name medication, how often, how much OR whether to cease)	<b>Action(s) by, or arranged by whom</b>	<b>By when (Date)</b>	<b>Next review (date)</b>
			Done <input type="checkbox"/>	
			Done <input type="checkbox"/>	
			Done <input type="checkbox"/>	
			Done <input type="checkbox"/>	

Completed by (please print)

Signature



### Syndrome specific list for general practitioners

SYSTEM	CEREBRAL PALSY 1:500	DOWN SYNDROME 1:700	PRADER-WILLI 1:25,000
<b>AUDIOVISUAL</b>	Visual: Increased risk of cicatricial retinopathy of prematurity, cortical visual impairment, strabismus Hearing: Sensorineural hearing	Visual most common - Refractive errors (myopia, hyperopia, astigmatism), Strabismus, Nystagmus, Keratoconus, and cataracts Hearing: Otitis media affects 50 to 70% DS children, conductive and sensorineural hearing loss Annual assessments recommended	Strabismus Myopia
<b>ENDOCRINE</b>		Thyroid dysfunction & diabetes (both hypo or hyperthyroidism) – Hypo is more common Annual TFT recommended Growth, short stature Obesity and diabetes Osteoporosis	Hypothalamic & pituitary dysfunction Growth hormone deficiency Adrenal insufficiency Hypothyroidism, Type 2 Diabetes, Hypogonadism, Osteoporosis Delayed puberty
<b>PSYCHIATRIC/ PSYCHOLOGICAL</b>	Depression Not all have intellectual disability	Depression, anxiety, OCD Alzheimer's type dementia (Clinical onset uncommon before 40 years)	Hyperphagia Impulse control difficulties Self-injury Depression, anxiety, psychosis Not all have intellectual disability
<b>C.N.S.</b>	Epilepsy	Epilepsy (Usually clonic/tonic)	Epilepsy
<b>CARDIOVASCULAR</b>		Congenital Heart Defects (Common - in 40 to 50%)	Hypertension
<b>MUSCULO-SKELETAL</b>	Contractures, scoliosis, joint dysfunction Managing pain, maintaining range of movement, muscle strength and general fitness Physiotherapy to monitor muscular function.	Joint laxity and hypotonia Predisposition to osteoarthritis Atlantoaxial dislocation, instability	Scoliosis Kyphosis Hypotonia
<b>ADDITIONAL</b>	Genito-urinary problems Incontinence, Constipation Dental problems Recurrent aspiration Oesophagitis, Reflux ± bleeding/ anaemia; Swallowing/eating difficulties – Speech disorders affect 40-50%; Abnormal function of oropharyngeal muscles Orthopaedic disorders; Osteopenia Pulmonary disease (caused by reflux & aspiration) Growth failure	Blood dyscrasias Childhood leukaemia – AML, ALL Sleep apnoea Increased risk of infections Coeliac disease Urological abnormalities Skin disorders, alopecia, eczema Gastrointestinal abnormalities	Infantile failure to thrive, then hyperphagia and severe obesity High tolerance to pain Decreased ability to vomit Sleep apnoea Undescended testes Dental Abnormalities Gastroesophageal reflux Skin picking
<b>INHERITANCE</b>	75% prenatal causes 8-10% perinatal asphyxia	Most cases are sporadic; 4% due to translocation involving chromosome 21 or rarely, parental mosaicism	Atypical. Most cases are sporadic.

### Syndrome specific list for general practitioners

<b>SYSTEM</b>	<b>RETT 1:10,000 FEMALES</b>	<b>NOONAN &lt;1:10,000</b>	<b>TUBEROUS SCLEROSIS 1:6,000-17,000</b>	<b>NEUROFIBRO MATOSIS Type 1 - 1:3,000 Type 2 - 1:30,000</b>
<b>AUDIOVISUAL</b>	Refractory errors	Strabismus, refractive errors Vision/hearing impairments	Retinal tumours Eye rhabdomyomas	Hearing impairment (Glioma affecting auditory nerve) Optic gliomas
<b>ENDOCRINE</b>				Various endocrine abnormalities
<b>PSYCHIATRIC/ PSYCHOLOGICAL</b>	Intellectual disability	Intellectual disability	Variable intellectual capacity Sleep problems Hyperactivity Aggressive behaviour Autism spectrum disorder Not all have intellectual disability	Increased risk of attention deficit disorders Not all have intellectual disability
<b>C.N.S.</b>	Epilepsy Vasomotor instability	Epilepsy	Cerebral astrocytomas Epilepsy	Variable clinical phenomena depending on site of the tumours Epilepsy
<b>CARDIOVASCULAR</b>	Prolonged QT interval	Pulmonary Valvular Stenosis ASD, VSD, PDA	Rhabdomyomas Hypertension	Rarely structural cardiac complications Increase in blood pressure with age
<b>MUSCULO-SKELETAL</b>	Osteopenia Fractures Scoliosis Gate abnormality	Scoliosis Talipes equinovarus Pectus carinatum/ excavatum	Bone Rhabdomyomata	Skeletal abnormalities esp. Kyphoscoliosis
<b>ADDITIONAL</b>	Hyperventilation Apnoea Reflux Feeding difficulties Growth failure Partial or complete loss of acquired spoken language Partial or complete loss of purposeful hand skills Impaired sleep pattern	Abnormal clotting factors, Platelet dysfunction Undescended testes, Deficient spermatogenesis Lymphoedema Hepatosplenomegaly Cubitus valgus, Hand abnormalities Characteristic facial features Short stature (80%)	Kidney & lung hamartomata Polycystic kidneys Liver Rhabdomyomata Dental abnormalities Skin lesions Subependymal nodules	Variable clinical phenomena depends on neurofibroma location Tumours susceptible to malignant change Cafe au lait spots Axillary and inguinal freckling Usually back pain & headaches Pheochromocytoma & renal artery stenosis rare
<b>INHERITANCE</b>	Usually sporadic. X linked	Autosomal dominant, may be sporadic	Autosomal dominant	Autosomal dominant

### Syndrome specific list for general practitioners

SYSTEM	FRAGILE X 1:4,000 to 7,000 <sup>1</sup>	PHENYLKETONURIA 1:13,500-1:19,000	ANGELMANN SYNDROME 1:10,000-52,000	WILLIAMS <1:20,000
<b>AUDIOVISUAL</b>	Visual Impairment – Multifactorial, Strabismus Hearing Impairment - Recurrent ear infections		Glaucoma Strabismus is possible	Hyperacusis Strabismus
<b>ENDOCRINE</b>	Primary ovarian failure in carriers			Diabetes Hypercalcaemia Hypothyroidism
<b>PSYCHIATRIC/ PSYCHOLOGICAL</b>	Attention deficit/ hyperactivity Social difficulties Anxiety & Autism Spectrum Disorders Not all have intellectual disability	Phobic anxiety Social difficulties Excessive sadness, fear & anxiety; sense of isolation & poor self-image Not all have intellectual disability	Easily excitable Hyperactive Intellectual disability	Attention deficit problems in childhood Not all have intellectual disability
<b>C.N.S.</b>	Epilepsy (Usually clonic/tonic, complex partial)	Epilepsy Hyperactivity Tremor & pyramidal tract signs Extrapyramidal syndromes	Epilepsy	Perceptual & motor function reduced
<b>CARDIOVASCULAR</b>	Aortic dilatation, Mitral Valve prolapse (related to connective tissue dysplasia)			Cardiac abnormalities Hypertension, CVAs Chronic hemiparesis
<b>MUSCULO- SKELETAL</b>	Connective tissue dysplasia Scoliosis Congenital hip dislocation	Osteopenia	Joint contractures & scoliosis (in adults)	Joint contractures Scoliosis Hypotonia
<b>ADDITIONAL</b>	FXTAS in carriers Herniae (CT related) Abnormalities of speech & language Avoidant behaviour Delayed language development Obesity & hyperphagia	Eczema Low phenylalanine diet provides considerable benefit	Speech impairment, Movement & balance disorder; Characteristic EEG changes; Gastrointestinal problems; Orthopaedic problems; Sleep problems; Obesity; Microcephaly	Renal abnormalities Short stature Characteristic facial features (elfin) Gastrointestinal problems
<b>INHERITANCE</b>	X linked	Autosomal recessive	Variety of genetic mechanisms on Chromosome 15	Microdeletion on chromosome 7

**Adapted from an original unpublished version by Michael Kerr and Glyn Jones.**

<sup>1</sup> Permutation prevalence – 1 in 130-250 females; 1 in 250-810 males (see: [http://www.irdjournal.com/files/IRD\\_2014Vol3No4\\_pp100\\_182.pdf](http://www.irdjournal.com/files/IRD_2014Vol3No4_pp100_182.pdf))

A 

V 

T 

U 

X 

O 

H 

**If the person has difficulty naming letters from the Snellen Chart,  
ask them to point to the corresponding letter on this page.**

**Health.gov.au**

All information in this publication is correct as at September 2024

