



# Preventive Care Checklist Form • Females with Intellectual or Developmental Disabilities (IDD)

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Please note:

**Bold** = Good evidence\*

*Italics* = Fair evidence\*

Plain text = Guidelines\*\*

Highlighted = Differences with respect to IDD

\*(Canadian Task Force on Preventive Health Care and U.S. Preventive Services Task Force); \*\* (other Canadian and U.S. sources)

## Etiology of IDD, if known:

## Capacity to consent:

☐ Capable ☐ Substitute Decision Maker

☐ Conservator/Guardian ☐ Power of Attorney

How was this decided: \_\_\_\_\_

## Living situation:

☐ Family ☐ Foster home

☐ Group home ☐ Independent

☐ Other: \_\_\_\_\_

Last/First Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yy

Medical Record Number: \_\_\_\_\_

Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ ☐ Initial visit ☐ Follow-up  
dd mm yyyy

## Advance Care Planning Needs:

☐ Living Will ☐ Financial Power of Attorney

☐ Consent for ECT ☐ Code Status

☐ Durable Power of Attorney for Health Care

Date of last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_  
dd mm yy

☐ Regular duration of period \_\_\_\_\_

☐ Age of menarche \_\_\_\_\_

## Lifestyle/Habits

☐ Underweight

☐ Overweight

☐ Exercise

☐ Alcohol

☐ Illicit Drugs

☐ Sexual History

☐ Diet \_\_\_\_\_

☐ Tobacco use packs/day \_\_\_\_ date quit \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Sleep \_\_\_\_\_

☐ Family \_\_\_\_\_

☐ Relationships (recent changes?) \_\_\_\_\_

☐ Day Program/Work \_\_\_\_\_

☐ Contraception/Family Planning \_\_\_\_\_

## Current Concerns

## Review of Systems

|                                 | Normal                   | Remarks |
|---------------------------------|--------------------------|---------|
| Constitutional Symptoms:        | <input type="checkbox"/> | _____   |
| HEENT:                          | <input type="checkbox"/> | _____   |
| CVS:                            | <input type="checkbox"/> | _____   |
| Resp:                           | <input type="checkbox"/> | _____   |
| GI:                             | <input type="checkbox"/> | _____   |
| Screen: GERD                    | <input type="checkbox"/> | _____   |
| Constipation                    | <input type="checkbox"/> | _____   |
| Diarrhea                        | <input type="checkbox"/> | _____   |
| H.pylori                        | <input type="checkbox"/> | _____   |
| GU:                             | <input type="checkbox"/> | _____   |
| Sexuality Issues:               | <input type="checkbox"/> | _____   |
| MSK/mobility:                   | <input type="checkbox"/> | _____   |
| Fall assessment (if indicated): | <input type="checkbox"/> | _____   |
| Derm:                           | <input type="checkbox"/> | _____   |
| Neuro:                          | <input type="checkbox"/> | _____   |

## Review of Systems

|  | Normal  | Remarks |
|--|---|---------|
| <b>Cognitive Changes:</b>  | <input type="checkbox"/>  | _____   |
| <input type="checkbox"/> Functional assessment (if indicated)                        |   | _____   |
| <input type="checkbox"/> Dementia screen (if indicated)                              |   | _____   |
| <b>Behavioral Changes:</b>   | <input type="checkbox"/>  | _____   |
| <input type="checkbox"/> Difficult or challenging behaviors                          |   | _____   |
| <input type="checkbox"/> Possible pain/distress                                      |   | _____   |
| <input type="checkbox"/> Possible abuse or neglect or exploitation (screen annually) |   | _____   |
| <b>Mental Health</b>   | <input type="checkbox"/>  | _____   |
| <input type="checkbox"/> Depression screen   | <input type="checkbox"/> positive <input type="checkbox"/> negative |         |

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

### EDUCATION / COUNSELING

#### Health Behaviors:

- ☐ **Folic acid** (0.4-0.8 mg/d, for childbearing women)
- ☐ *Adverse nutritional habits*
- ☐ *Dietary advice on fat/cholesterol (30-69 yrs)*
- ☐ Dietary advice on fruits and leafy green vegetables
- ☐ Adequate calcium intake (1000-1500 mg/d)<sup>1</sup>
- ☐ Adequate vitamin D (400-1000 IU/d; 800-1000 IU/d > 50 yrs)
- ☐ *Regular, moderate physical activity*
- ☐ *Weight loss counseling, if overweight*
- ☐ *Avoid sun exposure, use protective clothing*
- ☐ *Safe sex practices/STI counseling*
- ☐ Aspirin for CVD (55-79 yrs) if benefits outweigh risks of hemorrhage

**Alcohol** ☐ Yes ☐ No

- ☐ *Case finding for problem drinking*
- ☐ *Counseling for problem drinking*

**Tobacco use** ☐ Yes ☐ No

- ☐ Cessation program
- ☐ Nicotine replacement therapy
- ☐ *Referral to validated smoking cessation program*

#### Personal Safety

- ☐ Noise control programs ☐ Hearing protection
- ☐ Seat belts ☐ **Bicycle helmets**
- ☐ **Propensity to ingest noxious substances (pica)**
- ☐ Propensity to elope/wander

#### Oral Hygiene (q6mths)

- ☐ **Regular dental care**
- ☐ **Brushing/flossing teeth**
- ☐ **Fluoride (toothpaste/supplement)**
- ☐ *Tooth scaling and prophylaxis*
- ☐ **Smoking, tobacco cessation**

### PHYSICAL EXAMINATION

| HR: _____ | BMI: _____ OR  |  | Normal                   | Remarks |
|-----------|--|--|--------------------------|---------|
| BP: _____ | Waist Circum. _____ Hip Circum. _____ OR   | Neck/Thyroid:                                  | <input type="checkbox"/> | _____   |
| RR: _____ | Waist-hip ratio _____  | CVS:   | <input type="checkbox"/> | _____   |
| HT: _____ | (If BMI is 30 kg/m <sup>2</sup> or higher, discuss lifestyle changes or refer for behavioral intervention) | Resp:  | <input type="checkbox"/> | _____   |
| WT: _____ |  | General:                                       | <input type="checkbox"/> | _____   |
|           |  | Derm:  | <input type="checkbox"/> | _____   |
|           |  | <b>Breasts:</b>                                | <input type="checkbox"/> | _____   |
|           |  | Abdo:  | <input type="checkbox"/> | _____   |
|           |  | Ano-Rectum:                                    | <input type="checkbox"/> | _____   |
|           |  | Pelvic: <input type="checkbox"/> <i>Pap</i>    | <input type="checkbox"/> | _____   |
|           |  | MSK/Joints/Scoliosis/<br><b>Mobility aids:</b> | <input type="checkbox"/> | _____   |
|           |  | Extremities:                                   | <input type="checkbox"/> | _____   |
|           |  | Neuro:   | <input type="checkbox"/> | _____   |

|                             | Normal                   | Remarks |
|-----------------------------|--------------------------|---------|
| Eyes:                       | <input type="checkbox"/> | _____   |
| <i>Snellen sight card:</i>  | R _____ L _____          |         |
| Ears:                       | <input type="checkbox"/> | _____   |
| <i>Hearing Screening:</i>   | R _____ L _____          |         |
| Nose:                       | <input type="checkbox"/> | _____   |
| Mouth/Throat/ <b>Teeth:</b> | <input type="checkbox"/> | _____   |

### LAB/INVESTIGATIONS

- ☐ **Mammography** (50 until 74 yrs, q1-2yrs; consider if 40-49 yrs)
- ☐ **Hemoccult mult phase q1-2 yrs** (age  $\geq$ 50 up to 75 yrs) **OR**
  - ☐ *Sigmoidoscopy q5 yrs with fecal occult blood test q3 yrs*
- OR** ☐ Colonoscopy q10 yrs
- ☐ Cervical Cytology q1-3 yrs (sexually active until age 65) or for ages 30-65 yrs, screen with cytology and HPV testings q5 yrs
- ☐ **Gonorrhea/Chlamydia/Syphilis/HPV<sup>3</sup> screen** (high risk)
- ☐ **HIV screen** (age 15-65 yrs)
- ☐ Fasting Lipid Profile ( $\geq$  45 yrs or postmenopausal, or sooner if at risk)<sup>2</sup>
- ☐ Fasting Blood Glucose, at least q3 yrs for adults with sustained blood pressure of 135/80
- ☐ *Bone Mineral Density if at risk 21-64 yrs<sup>1</sup>;  $\geq$  65 yrs q 2-3 yrs if normal and q1-2 yrs if abnormal<sup>1</sup>*
- ☐ **Audiology assessment, if indicated by screening, & q 5 yrs after age 45**
- ☐ **Thyroid (TSH/T 4) q 1-5 yrs, if elevated risk or behavior change**
- ☐ Individualized periodic assessments

### IMMUNIZATION

Please see the current immunization schedule for adults at the Centers for Disease Control and Prevention website:

[www.cdc.gov/vaccines/schedules/hcp/adult.html](http://www.cdc.gov/vaccines/schedules/hcp/adult.html)

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

## ASSESSMENT AND PLANS

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

## REFERENCES

**DD references:** Sullivan WF et al. Primary care of adults with developmental disabilities: Canadian consensus guidelines. *Can Fam Physician* 2011;57:541-53. Unless otherwise stated, recommendations come from the Canadian Task Force on Preventive Health Care: *The Canadian Guide to Clinical Preventive Health Care*. Ottawa: Minister of Supply and Services Canada and [www.canadiantaskforce.ca](http://www.canadiantaskforce.ca).

1. Scientific Advisory Board, Osteoporosis Society of Canada. 2010 Clinical practice guidelines for the diagnosis and management of osteoporosis in Canada: summary. *CMAJ* 2010;DOI:10.1503/cmaj.100771
2. Working Group on Hypercholesterolemia and Other Dyslipidemias. Recommendations for the management and treatment of dyslipidemia and the prevention of cardiovascular disease: 2006 update. *Can J Cardiol* 2006;22(11) 913-927.
3. Expert Working Group on Canadian Guidelines for STIs. *Canadian Guidelines on Sexually Transmitted Infections*, 2006 edition. Ottawa: Public Health Agency of Canada.