CUMULATIVE PATIENT PROFILE

For adults with IDD

Adapted from template originally developed by the Department of Family and Community Medicine, Faculty of Medicine, University of Toronto, and Electronic Medical Record, DFCM, St. Michael's Hospital, Toronto

Initial Assessment Completed: ____/____/____ (dd mm yyyy)

Consider annual review, and update sooner when changes occur, e.g., decision-making capacity

Last/First Name: ______________________

Address: ______________________

____

Etiology of DD: ______________________

☐ Definite ☐ Probable ☐ Possible ☐ Unknown

Phone: __________ DOB ____/____/____ (dd mm yyyy) Gender: _____

Medical Record Number: ______________________

Genetic assessment: ☐ No ☐ Yes **Date:** ___/___/___

Report on file? ☐ No ☐ Yes

Findings of genetic assessment:

Psychological assessment: ☐ No ☐ Yes **Date:** ___/___/___

Report on file? ☐ No ☐ Yes

Findings of psychological assessment:

Living situation:

☐ Lives alone ☐ Lives with family ☐ Group home

☐ Supported living ☐ Nursing Home ☐ Other

Level of adaptive functioning:

☐ Mild ☐ Moderate ☐ Severe

☐ Profound ☐ Unknown

Last grade/degree completed: ______________________

Approximate reading level: ______________________

DECISION-MAKING CAPACITY

Decision-Making Capacity:

☐ Capable ☐ Not capable ☐ Unsure

Capacity to consent may vary over time and with the type of decision. Assess when proposing interventions for which consent is required. See Informed Consent Tool

Substitute Decision Maker:

Name: ______________________

Contact Information: ______________________

How was the substitute decision maker chosen:

Next of Kin: (if not Substitute Decision Maker):

Name: ______________________

Contact Information: ______________________

Others who may be helpful in decision making:

(e.g., Conservator/Guardian, Power of Attorney for Health Care, helpful agencies/ support persons)

SPECIAL NEEDS AND COMMUNICATION

Usual Clinic Visit Routines:

☐ Prefers early day ☐ Prefers end of day

☐ Limit time in waiting room ☐ Special positioning for exam

☐ Extra staffing needed ☐ May require sedation

Tolerates venipuncture? ☐ No ☐ Yes

☐ Other: ______________________

Expressive Communication (method, devices):

____

Receptive Communication – prefers:

☐ Pictures ☐ Simple explanations

☐ Written ☐ Sign language

☐ Other: ______________________

Triggers (e.g., trauma, noise, lighting, smells, color, textures):

Response Behaviors:

How to help:

Usual Response to Medical Exam:

☐ Fully/partially cooperates ☐ Fearful

☐ Resistant ☐ Aggressive

Usual Response to Pain or Distress:

☐ Typical ☐ Unique (describe):

Cautions (e.g., aggression, pica, aspiration risk): – specify modifications, precautions

PROBLEM LIST

Date	Billing Code	**PROBLEM LIST – Current Problems** (description, date identified, associated diagnoses)

CURRENT MEDICATIONS

CURRENT MEDICATIONS

Start Date	**Name of Medication and Directions** (dose, route, frequency, any specific instructions) **Asterisk (*) to indicate if prescription is refillable**

RECORD OF PAST MEDICATIONS

RECORD OF PAST MEDICATIONS

Start Date	Stop Date	**Name of Medication and Directions** (dose, route, frequency, specific instructions)	**Comments** Reason for discontinuation (e.g., ineffective, adverse effect, treatment complete)

ALLERGIES (include medications, food, stinging insect, pollen and dander, other)

ALLERGIES

Allergy	**Medication Reaction Type** (allergy, side effect, exaggerated, other effect)	**Reaction Severity** (life threatening, major reaction, minor reaction, no reaction)	**Status** (confirmed, suspected)	Brief Description of the Reaction	**Treatment Details** (optional)

IMMUNIZATIONS

IMMUNIZATION	Year	Year	Year	Year

FAMILY AND PAST HEALTH HISTORY

FAMILY HISTORY	**PATIENT'S PAST HISTORY** (including hospitalizations)

PERSONAL HISTORY

PERSONAL HISTORY

Most important relationships:

Caregivers and supports:

Employment or Day Program (indicate total hours/week):

Leisure Activities:

Nutrition, Dietary:

Exercise:

Sexually active:

Past ☐ No ☐ Yes ☐ Unknown

Current ☐ No ☐ Yes ☐ Unknown

RISKS

RISKS

Tobacco

Alcohol

Street Drugs

Behavior

ROUTINE HEALTH MAINTENANCE

ROUTINE HEALTH MAINTENANCE

Periodic Tests	Date	Date	Date	Date	Date	Comments or follow-up
Vision						
Hearing						
Dental						
Pap test						
Colon cancer screening						
Mammography						
Bone Density						

Advance Planning Needs:

☐ Transition ☐ Crisis ☐ Palliative ☐ End of Life ☐ DNR-If yes, record on file?

Other: ____

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