

**Please note:** this form is designed to be completed on **Adobe Acrobat Reader** or an equivalent PDF reader.

Please email your completed form to [cddh@monashhealth.org](mailto:cddh@monashhealth.org)

<b>Name of person completing this form (a.k.a. Referrer)</b>	
<b>Referrer contact details (inc. email, role and organisation)</b>	
<b>Best contact person (inc. phone number and email address) if different from referrer</b>	
<b>Patient name</b>	
<b>Patient address</b>	
<b>Patient telephone number</b>	
<b>Patient date of birth</b>	
<b>Patient Medicare number</b>	
<b>Is the patient of Aboriginal but not Torres Strait Islander background?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Is the patient of Torres Strait Islander but not Aboriginal background?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>In which country was the patient born?</b>	
<b>Is the patient of a non-English speaking background?</b>  <b>If a consultation is recommended, is an interpreter, or other assistance with communication required at the consultation?</b>	YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, what is the patient's first language? _____ YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>Name, address, phone number and email of GP</b>	

<p><b>Medical Treatment Decision Maker</b> The medical treatment decision maker for a person is the first person, 18 years of age or older, in the list below. They must be reasonably available and willing and able to make the decision. Where there are two or more relatives who are first on this list, the eldest is the medical treatment decision maker. <b>PLEASE TICK THE APPROPRIATE BOX:</b></p> <p>The person's legally appointed medical treatment decision maker</p> <p>A guardian appointed by the Victorian Civil and Administrative Tribunal to make decisions about medical treatment for the person</p> <p>The first of the following people who is in a close and continuing relationship with the person:</p> <ul style="list-style-type: none"> <li>the person's spouse or domestic partner</li> <li>the person's primary carer (<i>Paid Disability Support Workers are NOT legally allowed to consent on behalf of the patient</i>)</li> <li>an adult child of the person</li> <li>a parent of the person</li> <li>an adult sibling of the person.</li> </ul> <p>Note: Appointments made before the Medical Treatment Planning and Decisions Act commenced on 12 March 2018 are valid.</p>	<p>Name and relationship to patient:</p> <p>Address:</p> <p>Phone:</p> <p>Email:</p> <p>Has the MTDM been notified of the appointment? Yes                      No</p> <p>If 'No', we ask that you notify the MTDM ASAP.</p> <p><b>If there is a legally appointed Medical Treatment Decision Maker, or a VCAT Guardian, please provide us with documentation to confirm it.</b></p>
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<b>Consent</b>	
For consultations, does the Medical Treatment Decision Maker consent to:	
<i>The referral for assessment by the Centre for Developmental Disability Health.</i>	Yes      No
<i>An audit of the patient's file, if selected, for 'quality of care' review.</i>	Yes      No
<i>The sharing of relevant information to the following people involved in the person's care (please tick the relevant boxes):</i>	
General Practitioner	Speech therapist
Medical Treatment Decision Maker	Physiotherapist
House supervisor	Medical specialist
Behaviour Support Practitioner	Day program coordinator
Occupational Therapist	NDIS Support Coordinator
For medical procedures, as part of the evaluation of the Disability Health Access Service, a research project is being conducted to evaluate the needs and outcomes of the service. The data will be stored on the Electronic Medical Records system and research relating to the data will be kept for 7 years post-completion. Does the Medical Treatment Decision Maker consent to:	
<i>A collection of your (the patient's) personal and de-identified health information (e.g. primary diagnosis, medical history etc.)</i>	
<b>Yes      No</b>	
<i>Follow-up contact regarding your (or the patient's) experience in relation to the DHAS?</i>	
<b>Yes      No</b>	



If you (or your patient) wish to have a consultation regarding a medical or psychological issue, **please go to page 4.**

If you (or your patient) wish to have investigations undertaken through the Disability Health Access Service, **please go to page 11.**

If you (or your patient) wish to be referred to both services, **please fill out the entire form.**

<p><b>Reason for referral</b>  What is your main concern?  What are the goals you hope to achieve for the patient?  How do you see CDDH helping you to meet these goals?</p>	
<p><b>Behaviour history</b>  Are there Behaviours of Concern? If so, what are they?  What is the patient normally like?  How are the Behaviours of Concern different to the patient's normal presentation?  How often it is happening?  When did it start?  Have the Behaviours of Concern changed over time?  What changed about the person's life around the same time? Consider all aspects of their life, such as medical illness, medication, home, family, and day activities.</p>	
<p><b>Are there any signs of physical illness?</b>  For example:</p> <ul style="list-style-type: none"> <li>• Reduced appetite</li> <li>• Change in bowel motions</li> <li>• Change in mobility</li> <li>• Loss of skills/function</li> </ul>	
<p><b>Is the person at risk of falls?</b>  <b>Is the person at risk of pressure injuries?</b></p>	<p>Yes    No  Yes    No</p>
<p><b>Are there any signs of mental illness?</b>  For example:</p> <ul style="list-style-type: none"> <li>• Seeing and/or interacting with something that isn't there</li> <li>• Change to sleep pattern</li> <li>• Change to speech pattern</li> <li>• Change to mood</li> </ul>	

<p><b>Medical history</b> Please tell us the person's medical history, including their height, weight, and any recent hospital admissions. <b>Please do not submit your referral without a GP Full Summary or Medication Treatment Sheet. If you can't, please list any medications the person is on.</b></p>	
<p><b>Disability diagnosis</b></p> <ul style="list-style-type: none"> <li>• What is the formal diagnosis, if known (e.g. Cerebral Palsy, Autism Spectrum Disorder, Down Syndrome)?</li> <li>• If any, what is their degree of Intellectual Disability?</li> <li>• Have any genetic tests been performed, particularly in the last 5 years?</li> </ul>	
<p><b>How do they communicate?</b> Please be specific e.g. verbal, gestures, facial expressions, communication device.</p>	
<p><b>What is their function in terms of...?</b></p> <ul style="list-style-type: none"> <li>• Mobility</li> <li>• Personal care (e.g. feeding, dressing, toileting)</li> <li>• Domestic tasks</li> <li>• Community tasks (e.g. money handling, taking public transport)</li> </ul>	
<p><b>Current health professionals involved</b> Please list all the types of clinicians (other than the GP), including medical specialists, nursing and allied health. Please put their contact details on page 7.</p>	
<p><b>Family medical/psychiatric history</b></p>	
<p><b>Social history</b></p> <ul style="list-style-type: none"> <li>• Family relationships/involvement</li> <li>• Relationship with co-residents</li> <li>• Living arrangements, including client-to-carer ratio</li> <li>• Day activity (Which day program do they attend? How often do they go? Do they have 1:1 Disability Support Worker support?)</li> <li>• What does the person enjoy doing?</li> </ul>	

*Please submit any available versions of the following documents and check the box when submitting your referral.*

- GP Full Summary/Treatment sheet (**Please do not submit your referral without this**)
- NDIS Plan
- School reports
- Cognitive assessments (e.g. IQ testing, conducted by a Psychologist)
- Communication assessments (conducted by a Speech Pathologist)
- Behaviour Support Plan (conducted by a Disability Support Worker or Behavioural Intervention Specialist)
- Functional assessments (conducted by an Occupational Therapist)
- Sensory assessments (conducted by an Occupational Therapist)
- Psychology reports
- Psychiatry reports
- Previous brain scans
- Blood tests

**NB** if dementia is suspected, please provide results for the following tests: FBE, UEC, LFTs, Calcium/Magnesium/Phosphate, B12/folate, thyroid function test, iron studies, urine M/C/S. If unavailable, please see your GP to order them.

- Genetic test reports
- Comprehensive Health Assessment Program (a.k.a. CHAP) (conducted by a GP)
- Vision/hearing reports

Significant people

Please list the contact information of all individuals involved in the patient's care, particularly allied health professionals (speech pathologist, occupational therapist, behaviour support practitioner etc.) and medical professionals (aside from the GP).

<b>Role</b>	<b>Name</b>	<b>Address</b>	<b>Phone</b>	<b>Email (or fax, if email is not available)</b>
Key family members				
House supervisor				
Day Placement (specify organisation)				
NDIS support coordinator (specify organisation)				
Pharmacist				
Other (specify):				
Other (specify):				

**TO BE COMPLETED ONLY IF DEPRESSION IS SUSPECTED OR IF THERE ARE BEHAVIOURS OF CONCERN**

**Depression in Adults with Intellectual Disability: Checklist for Carers**

**Who is the checklist for?**

The Depression Checklist is for use by carers, in particular paid support staff. It is intended to be completed on behalf of adults who are unable to report their own feelings or symptoms because of severe communication impairment.

**What does the checklist provide?**

It provides carers with a means of ensuring they have noted and recorded the information that is needed by a medical practitioner to decide

- if an adult with intellectual disability may have depression or related mental health problem, and
- if referral to a mental health specialist or practitioner is appropriate.

**Who should complete the checklist?**

The best person to complete the checklist is the person who has worked longest with the adult and can provide all the information required. For some people who are relatively new to a service, it may best be completed by consultation between more than one carer, including a family member.

**Is the Checklist a diagnostic tool?**

**No.** The checklist provides information for use by a medical or mental health practitioner in screening for possible depression or related disorders, in adults who are unable to self-report.

**How should the Checklist be used?**

**The Checklist should be completed by a carer prior to attending a medical consultation with a GP. Hence, it should be given to the GP with other information about the history of the adult and further information of relevance to his/her health care.**

It can also be taken to a consultation with a mental health professional.

It is recommended that the Checklist be dated and kept in the adult's home medical file, as this will provide a record of changes in any of the symptoms noted.

**How was the Checklist developed?**

It was developed by Dr. Jennifer Torr (MBBS, Mmed – Psychiatry, FRANZCP, member Faculty Psychiatry of Old Age), Director of Mental Health at the Centre for Developmental Disability Health Victoria.

The first trial of the Checklist was in a study conducted by CDDHV psychiatrists and researchers, with follow-up evaluations. Details can be found at <http://www.cddh.monash.org>



# Depression in adults with intellectual disability

## Checklist for carers

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

Check **L** if the item/symptom has been present over a **LONG** period of time (i.e. It is considered a part of the patient's normal behaviour.)

Check **C** if there is a **CHANGE**. This means that the item/symptom is new and has been occurring for 2 weeks or longer.

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

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

### **Additional information**

If there was any information or details that you were unable to fit into the fields provided, feel free to use the space below.

## Disability Healthcare Access Service Screening Tool

### ELIGIBILITY FOR SERVICE

Is the person aged 16 years or over?

Yes No

Does the person have an intellectual and/or developmental disability?

Yes No

If you ticked 'No' for either of these answers, then you (or your patient) are not eligible for this service.

### Disability:

Intellectual Disability

Autism Spectrum Disorder

Cerebral Palsy

Mental Health

Other:

### Current Medications including PRNs (or attach a Treatment Sheet or GP Summary):

### Allergies:

### Medical Procedure History:

### Relevant Health History including Behavioural/Psych history (if any):

Do behaviours of concern usually present for medical treatments? Yes No

If so, list the behaviours: \_\_\_\_\_

### Methods and Strategies Previously Used:

Please tick if any of the below strategies have previously been **EFFECTIVE** for the individual.

### PRIMARY SUPPORT

*Support*; having a familiar support person present

*Communication*; such as use of 'social stories' to prepare a person for blood tests and other injections

*Clinical Setting*; person has had blood tests and other injections done at the GP clinic or pathology service

Additional comments:

### SECONDARY SUPPORT

*Home Environment*; blood tests and other injections always done at home successfully

*Behaviour Support Plan*; individualised strategies developed with behaviour specialist input or other (including known strategies by support person)

Additional comments:

### TERTIARY SUPPORT

*Pharmacological*; such as an anxiolytic or other PRN

List below:

*Sedation*; person has required General Anaesthetic/heavy sedation to have blood tests, immunisations, imaging, dental review

*No known history*; person has no known history of having blood tests or other injections (this may include reasons related to behavioural concerns)

Additional comments:

### **Additional support:**

*Does the person have support from someone familiar to them for the day of the procedure?*

YES NO

*If no, can they be accompanied by 2 additional supports on the day of the procedure?*

YES NO

**Reason for referral:**

Immunisations (Immunisation history to be included with referral)

Please provide details:

Physical examination (please specify any particular areas of concern)

Ear examination

Nail cutting      Hands      Feet

Pathology

Please provide details:

Medical imaging (x-ray, ultrasound, or CT scans **only**)

Please provide details (i.e. which type of scan, where, and on which side):

Oral health review

Please specify any particular concerns:

Cervical screening      Last screening completed:

Abnormalities      Yes      No

Is the person currently an inpatient or at risk of hospital admission or ED presentation:  Yes  No