**CONFIDENTIAL**

**LEARNING DISABILITY ANNUAL HEALTH CHECK TEMPLATE**

***For GP Practices using EMIS.***

This template is laid out identically to NHSE electronic Learning Disability Annual Health Check template. The key headings within the template have been adapted to incorporate non-medical words. They are easier for people with learning disabilities to understand and also help them to engage more in the health check. For further guidance on the learning disability Annual Health Check please refer to Royal College of General Practitioners Step by Step Toolkit for Annual for Annual Health Checks for people with learning disabilities

<https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx>

* **Request to see patient’s pre health check questions form. If not completed ask the patient if they have any health concerns**
* **Review medical notes before completing health check**

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| --- | --- |
| **Name:** |  |
| **Date of Birth:** |  |
| **NHS No:** |  |
| **Address:** |  |
| **Completed by (name and profession):** |  |
| **Date Completed:** |  |
| **CHECK: ARE EMERGENCY CONTACT DETAILS UP TO DATE?** | |

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| **HAPPY TO HAVE THE HEALTH CHECK - CAPACITY & CONSENT** | | |
| Are you happy to have the learning disability Annual Health Check?  Notes: | **Yes** | **No** |
| If the patient lacks the capacity to consent to the health check was a decision made to precede in the patients best interests? If yes who was involved in this decision? | **Yes** | **No** |
| Who is supporting the patient?  Name:  Role:  Contact No: | | |
| Is it okay to share health information with others (3rd parties) on a need to know basis for example a Paramedic, hospital Doctor? | **Yes** | **No** |
| Who is it okay to share information with?  Names:  Contact No’s: | | |
| Is it okay to share information on SCR with additional information regarding your Learning Disability? | **Yes** | **No** |
| Are you happy for other health professionals to see your health information to make your care better (CHIE) | **Yes** | **No** |
| If patient lacks capacity regarding sharing of information make a best interests decision. Document who was involved in this decision. | | |

**PLEASE CONSIDER ANY SPECIFIC TESTS OR CHECKS RELATING TO THE PERSON’S DISABILITY, SYNDROME OR CONDITION. CERTAIN GENETIC SYNDROMES CAN CAUSE INCREASED MORBIDITY.**

**For example: Dementia screening or thyroid testing for those**

**with Downs syndrome.**

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| **WHO HELPS ME - SUPPORT AND PATIENT INFORMATION** | | |
| Do you see any health professionals? If so who? | **Yes** | **No** |
| Do you have a carer? | **Yes** | **No** |
| If yes, who?  Name of Carer:    Contact No:  **\**If they are an unpaid carer please code accordingly and***  ***offer carer health check and flu vaccine.*** |  |  |
| Do you have a social worker?  Name:  Contact number: | **Yes** | **No** |
| Accommodation Status: *\*Also include whether the patient is housebound* | | |
| Employed? | **Yes** | **No** |
| What is your Job? | | |
| Status: (Single, married, widowed etc.) | | |

**IS THERE ANYTHING OUTSTANDING FROM RECENT LETTERS OR LAST YEAR’S HEALTH CHECK? IF SO, PLEASE CHECK**

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| **HEALTH CHECKS (Please tick)** | | |
| Have you had a health check before? | **Yes** | **No** |
| Do you have actions from my health check | **Yes** | **No** |
| Is there anything outstanding? | **Yes** | **No** |
| Are you worried about anything? | **Yes** | **No** |
| If you answered yes please state: | | |
|  | | |
| **14 – 17 YEAR OLDS ONLY** | | |
| What is the name of your school? | | |
| Do you have an Education, Health and Care Plan (EHCP)? \* If yes review section G (health section) of the plan. | **Yes** | **No** |
| Plans for post 18 (signpost if required) | | |
| Child Status (Looked After Child) | | |
| Do you have any health professional involvement, including Paediatrician? If so who and what are they helping you with? | | |

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| * Is the patient currently under transition from Child to Adult Health Services * (Physical and/or mental health)? * Do you need to start this process? * Make referrals as required. * Share health screening booklet (saved in electronic LD Annual Health Check folder). * Advise patient and family to access local county council webpages for further information on services etc. * Advise patient and family to access Southern Health NHS Foundation Trust website for details on local Community Learning Disability Teams https://www.southernhealth.nhs.uk/services/learning-disabilities/ |

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| **ALLERGIES** | | |
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| **INJECTIONS - IMMUNISATIONS** | | |
| Are you up to date with immunisations? | **Yes** | **No** |
| Date of last flu jab (injection or nasal spray?): | | |
| Tetanus | **Yes** | **No** |
| Polio | **Yes** | **No** |
| HPV | **Yes** | **No** |
| MMR | **Yes** | **No** |
| Pneumococcal Vaccination\*Offer to all children with respiratory conditions caused by aspiration or neurological condition | **Yes** | **No** |
| Hepatitis B | **Yes** | **No** |

**Hepatitis B vaccine SHOUILD BE CONSIDERED AND OFFERED WHERE Individuals LIVE IN shared accommodation AND/OR ATTEND DAY SERVICES. IN PARTICULAR WHERE THEY DISPLAY BEHAVIOURS SUCH AS BITTING OR AT RISK OF BEING BITTEN**

**Can any of the immunisations be given now?**

**If not- please document on actions from ‘my health check’ section**

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| **REASONABLE ADJUSTMENTS** | | |
| Does this patient need more time for appointments? | **Yes** | **No** |
| Consider best environment for health appointments: | | |
| Extra support with communication, such as easy read information, objects of reference? | **Yes** | **No** |
| Does the patient need an appointment at a specific time of day? Specify if required | **Yes** | **No** |
| Preferred method of communication e.g. Makaton, pictures  **ADD ANY REASONABLE ADJUSTMENTS TO PATIENTS ALERT IN MEDICAL NOTES**  **INCLUDE REASONABLE ADJUSTMENTS IN ALL NEW REFERRALS** | | |
|  | | |
| **MY WALKING & MOVEMENT - FUNCTIONAL LIFE SKILLS (MOBILITY)** | | |
| Describe mobility including use of mobility aids, support and/or advice (Life skills). Open to Physiotherapy? | | |
| Any permanent physical disability? | **Yes** | **No** |
| Any problems with joints, moving or co-ordination? | **Yes** | **No** |
| Any problems with posture, standing or spinal curvatures? | **Yes** | **No** |
| Any tremors or shaking? | **Yes** | **No** |
| Do you use any mobility, positioning aids or equipment? Are they fully working? | **Yes** | **No** |
| * Consider osteoarthritis, pain relief, vitamin D levels * Refer to GP, Physiotherapy, OT, and Community Learning Disability Health Team for additional support if they have a health need which cannot be met by mainstream health services. | | |

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| **DAY TO DAY LIVING - DAILY LIVING SKILLS** (Describe whether independent, requires prompts or dependant. Include any concerns) |
| Eating: |
| Drinking: |
| Getting dressed and undressed: |
| Having a wash: |
| Using the toilet: |
| Help with daily living skills: |
| Seen by Occupational Therapy? If yes specify interventions |
| Consider a referral to local Adult LD Social Care Team where appropriate |

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| **LIFESTYLE AND HEALTH PROMOTION** | | |
| Usual diet/what I like to eat: | | |
| Do you need a special diet? | Yes | No |
| What would you normally eat for:  Breakfast:  Lunch:  Tea/Dinner: | | |
| Consider referral to Dietetics | | |

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| **EXERCISE** |
| What activities do you do? |
| How often do you exercise? |
| Consider leaflet on healthy living and exercise.  [www.easyhealth.org.uk](http://www.easyhealth.org.uk) |

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| **SMOKING** | | |
| Do you smoke? | Yes | No |
| Did you used to smoke? | Yes | No |
| How many cigarettes do you smoke a day? | | |
| Would you like to stop smoking? | Yes | No |
| Does the patient require a referral to the stop smoking service? | | |

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| **DRUGS & ALCOHOL - ALCOHOL AND SUBSTANCE MISUSE** | | |
| Do you drink alcohol? | **Yes** | **No** |
| What do you drink? | | |
| How often and how much do you drink alcohol? | | |
| Do you take drugs/or legal highs? | **Yes** | **No** |
| If yes, what and how often? | | |

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| **SEX - SEXUAL HEALTH, CONTRACEPTIVE ADVICE AND RELATIONSHIPS** | | |
| Do you have a partner? | **Yes** | **No** |
| Have you ever had sex with anyone? | **Yes** | **No** |
| Do you know about contraception and what it does? | **Yes** | **No** |
| Do you know how people get pregnant? | **Yes** | **No** |
| Do you know about sexual diseases and how they are caused? | **Yes** | **No** |
| Would like any information on these issues? | **Yes** | **No** |
| Would you like to talk to someone? | **Yes** | **No** |
| Do you know it is okay to say **‘NO’** if you don’t want to have sex or be touched? | **Yes** | **No** |
| Do you know you must listen and stop if someone else says ‘**NO**’? | **Yes** | **No** |

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| **EASYREAD INFORMATION AVAILABLE AT:**  [**www.apictureofhealth.southwest.nhs.uk**](http://www.apictureofhealth.southwest.nhs.uk)  [**www.easyhealth.org.uk**](http://www.easyhealth.org.uk)  Consider referral to local sexual health clinic for contraception advice or health education.  Complete referral to Community Learning Disability Health Team and or Adult LD Social Services if risk of sexual exploitation is identified. |

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| **FEMALE SCREENING** | | |
| Have you noticed any problems or changes with your breasts or nipples? | **Yes** | **No** |
| Do you check your breasts every month? | **Yes** | **No** |
| Breast examination completed | **Yes** | **No** |
| (50+) Have you had your breast screening? | **Yes** | **No** |
| Health education advice given on breast examination and mammogram? | **Yes** | **No** |
| Have you ever had a smear test? | **Yes** | **No** |
| Date of last smear test and results. Are they overdue? |  |  |
| (25+) Are you due a smear test? | **Yes** | **No** |
| Health education advice given on smear tests? | **Yes** | **No** |
| Complete pelvic examination if indicated | **Yes** | **No** |

Easy read information available at [www.easyhealth.org.uk](http://www.easyhealth.org.uk)

https://www.southernhealth.nhs.uk/#

Consider desensitisation work for mammogram and/or smear test.

**CONTACT COMMUNITY LEARNING DISABILITY TEAM FOR GUIDNACE ON PATIENT HAVING A SMEAR TEST OR MAMOGRAM IF REQUIRED.**

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| **BOWEL SCREENING** | | |
| (60-74 years) Have you had bowel screening? If yes what were the results? | **Yes** | **No** |

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| **MEN’S HEALTH** | | |
| Testicular examinationcompleted | **Yes** | **No** |
| Do you check your testicles? | **Yes** | **No** |
| Health education advice given? | **Yes** | **No** |
| (65 years old) AAA screen completed? Results? | **Yes** | **No** |

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| **Prostate examination required** | **Yes** | **No** |
| Notes: |  |  |

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| **HEIGHT AND WEIGHT** | | | |
| Current height:  \*If unable to obtain height measurement use guidance outlined in MUST assessment | Current weight:  **\***If patient is unable to stand on scales consider using hoist, sitting or wheelchair scales | | |
| BMI :  \*If BMI is above 25 consider potential co morbidities | Waist Measurement: | | |
| Blood Pressure: / | | | |
| Health Checks above declined? If so state reason. **If patient declined due to anxieties can desensitisation work be completed?** | | | |
| **EYES AND VISION** | | | |
| Any problems with your eyes?  Level of eyesight: | | **Yes** | **No** |
| Any pain or itching? | | **Yes** | **No** |
| Do you wear glasses? | | **Yes** | **No** |
| Date/Year that you last had eye test?(Routine tests should be done every two years) | | | |
| If you have diabetes, have you been for Retinal Screening in the last year (as well as an eye test)? | | **Yes** | **No** |
| **EARS AND HEARING** | | | |
| Do you have a hearing or ear problems? | | **Yes** | **No** |
| Ear wax? | | | |

NOTE: Please physically examine both ears and add comments above.

Consider whispered voice test. Refer to audiology if appropriate.

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| **MOUTH AND TEETH** | | |
| Name of Dentist and Practice | | |
| Date of last dental appointment | | |
| Any dental recommendations? | | |
| Any problems with your mouth, teeth or gums? | **Yes** | **No** |
| Do you brush your teeth or dentures twice daily? | **Yes** | **No** |
| Do you have difficulty eating or chewing? | **Yes** | **No** |
| Do you think you have bad breath? | **Yes** | **No** |
| Do you have problems with dribbling? | **Yes** | **No** |
| Do you ever get mouth ulcers or cold sores? | **Yes** | **No** |

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| Consider referral to Specialist Community Dental Service if patient is not able to manage mainstream dentist. |

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| **HOW I AM FEELING – GENERAL SYMPTOMS** |
| Include patient and/or carer concerns and pain |

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| **BREATHING** | | | | |
| Do you have asthma? | | **Yes** | | **No** |
| Do you have any problems with your breathing e.g. wheezing? | | **Yes** | | **No** |
| Do you get short of breath? | | **Yes** | | **No** |
| Do you have a cough that is not getting better? | | **Yes** | | **No** |
| Do you bring up mucous or phlegm? | | **Yes** | | **No** |
| Do you have any blood in your spit? | | **Yes** | | **No** |
| Do you keep getting chest infections? | | **Yes** | | **No** |
| Additional comments: | |  | |  |
| **SWALLOWING** | | | | |
| Do you have any problems eating or swallowing? | **Yes** | | **No** | |
| Do you eat slowly or decline food/drink? | **Yes** | | **No** | |
| Do you find it hard to breathe whilst eating and/or drinking (shortness of breath)? | **Yes** | | **No** | |
| Do you cough when you eat and drink? | **Yes** | | **No** | |
| Do you cough after you eat and drink? | **Yes** | | **No** | |
| Does your voice sound “bubbly” after eating or drinking? | **Yes** | | **No** | |
| After eating do you have any pain? | **Yes** | | **No** | |
| Does food get stuck? | **Yes** | | **No** | |
| Do you bring up food? | **Yes** | | **No** | |
| Are you losing weight? | **Yes** | | **No** | |
| Additional comments: |  | |  | |
|  | | | | |
| **If yes to any of the above: conduct an examination of the oropharyngeal cavity, review medication to see if they have sedating or cholinergic side effects.**  **Make a referral to Speech and Language Therapy. Tel no: 01962 764 560 or Email** [**hp-tr.SALT@nhs.net**](mailto:hp-tr.SALT@nhs.net)**.**  **Also consider other causes for the above symptoms (gastrointestinal cancers are more common in people with learning disabilities).**  **Patients cerebral palsy, stroke, diagnosed dementia are more at risk from dysphagia.** | | | | |
| |  |  |  | | --- | --- | --- | | **HAAVING A POO- BOWELS** | | | | Do you ever get tummy/stomach pains? | **Yes** | **No** | | Do you have any pain when you go to the toilet? | **Yes** | **No** | | Do you ever find it difficult to poo (constipation)? \*the prevalence of constipation in people with LD is high.  Is yes explore causes of constipation and offer guidance | **Yes** | **No** | | Do you ever have very loose poo (diarrhoea)? | **Yes** | **No** | | Have you seen any blood, jelly or black in your poo? | **Yes** | **No** | | OVER 60’s: Have you done your bowel screening? | **Yes** | **No** | | Have you lost weight recently? | **Yes** | **No** | | Additional comments: |  |  | | | | | |

**Refer to Screening liaison nurse if bowel scope screening not complete (offered once at age 55) or bowel screening (60 -75 years, invited every 2 years).**

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| **Having a pee - BLADDER** | | | |
| Do you have any problems when you go for a pee? | | **Yes** | **No** |
| Have you had your pee tested recently? | | **Yes** | **No** |
| Do you ever find it hard to pee? | | **Yes** | **No** |
| Is your pee a dark colour? | | **Yes** | **No** |
| Does your pee smell? | | **Yes** | **No** |
| Do you find that you need to go for a pee more often? | | **Yes** | **No** |
| Do you ever have any accidents with your pee in the day or night (wet the bed)? | | **Yes** | **No** |
| Do you wear pads? | | **Yes** | **No** |
| If yes where do you get them? | |  |  |
| Additional comments: | |  |  |
| |  | | --- | | CONSIDER A REFERRAL TO THE BLADDER AND BOWEL SERVICE FOR INCONTINENCE PRODUCT OR THE CONTINENCE SERVICE |  |  |  |  | | --- | --- | --- | | **WOMEN’S HEALTH** | | | | Do you have periods? | **Yes** | **No** | | Do you have any problems with them? | **Yes** | **No** | | Menstrual advice given? | **Yes** | **No** | | Have you been through ‘The Change’ (menopause)? | **Yes** | **No** | | Are you having any problems (symptoms) with this? | **Yes** | **No** | | Additional comments: |  |  | | | | |
| **MY BRAIN/HEAD - CENTRAL NERVOUS SYSTEM AND EPILEPSY** | | | |
| Do you have any kind of epilepsy? | | **Yes** | **No** |
| Do you or someone else write down when you have a seizure?(ask to see recent epilepsy charts and care plans) | | **Yes** | **No** |
| Do you have an epilepsy nurse? | | **Yes** | **No** |
| Have you been seen in neurology? | | **Yes** | **No** |
| Date of appointment | Date of next appointment | | |
| Any changes in how you feel things? | | **Yes** | **No** |
| Have you had any seizures in the past? | | **Yes** | **No** |
| Assess for stroke symptoms. History of strokes | | | |
| Do you get headaches? | | **Yes** | **No** |
| Full neurological examination indicated? | | **Yes** | **No** |
| Additional comments: | |  |  |

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| **MY HEART - CARDIOVASCULAR SYSTEM** | | |
| Do you get chest pain? | **Yes** | **No** |
| Do you find it hard to breathe? (ask this for day and night time) | **Yes** | **No** |
| Any problems with your breathing or a cough? | **Yes** | **No** |
| Do you bring up mucous or phlegm? | **Yes** | **No** |
| Do your ankles swell? | **Yes** | **No** |
| Does your heart beat very fast (palpitations)**?** | **Yes** | **No** |
| Additional comments: |  |  |

MEN AGED 65 – Check they have had the AAA screen

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| **DIABETES** | | |
| Do you have diabetes? | **Yes** | **No** |
| Date of last HbA1c test:  If not checked in the last 12 months arrange a re check  Date of last Diabetes check: | | |
| Date of last Diabetic Retinopathy screening check:  **FOLLOW UP ANY OVERDUE DIABETES HEALTH CHECKS** | | |

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| **MY BONES - MUSCULOSKELETAL** | | |
| Is the patient at risk of osteoporosis? \*consider anti-epileptic medication, Profound and Multiple LD, cerebral palsy | **Yes** | **No** |
| Do you get pain in your bones? Where? | **Yes** | **No** |
| Number of falls in the last 12 months: | | |
| Additional comments: | | |

Complete posture assessment. If concerned refer to LD Physiotherapy.

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| **FEET** | | | |
| Observe both feet (add observations, deformities) | | | |
| Are you having any problems or pain with your feet? | **Yes** | **No** | |
| Do you need any special footwear? | **Yes** | **No** | |
| Who cuts your toenails? | **Yes** | **No** | |
| Do you ever see a chiropodist or podiatrist? | **Yes** | **No** | |
| If yes, when? (State date) | | | |
| Name of Chiropodist / Podiatrist: | | | |
| **ADDITIONAL SYMPTOMS** | | | |
| Include information on chronic pain, skin integrity etc. | | | |
| **HOW I AM FEELING** | | |
| Do you sleep well at night? | **Yes** | **No** |
| Do you wake up at night? | **Yes** | **No** |
| If not do you know why? (State reason) | | |
| How are you feeling? | | |
| Do you have anything worrying or upsetting you? | **Yes** | **No** |
| Do you have thoughts of hurting yourself or ending your life? | **Yes** | **No** |
| Do you have someone you can talk to about things? | **Yes** | **No** |
| Any behaviour that you have, which are a problem for you or anyone else? (Self-harm, aggression, rituals, etc.) | **Yes** | **No** |
| Do you have a mental illness? | **Yes** | **No** |
| Who looks after your mental health? | | |
| Do you seem more confused or forgetful? | **Yes** | **No** |
| Additional comments: |  |  |

Consider early onset dementia particularly in Down syndrome. If dementia suspected refer to Community Learning Disability Team

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| If the patient is presenting with changes or increase in behaviours which challenge consider whether there is an **underlying physical health** or other cause to this. If all physical health checks come back NAD consider a referral to the Community Learning Disability Team. |

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| **BODY HEALTH CHECK - EXAMINATIONS AND MEASUREMENTS** |
| Pulse rate and rhythm: |
| Respiratory system: |
| Digestive system: \*Complete abdominal examination and add notes from examination |
| Heart sounds: |
| Skin: |
| Pressure areas: |
| Female pelvis: (if needed) |

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| **BLOOD TEST RESULTS \* enter latest results** |
| HbA1c |
| Thyroid function test (Annually for patients with Down’s Syndrome) |
| Serum Cholesterol |
| Urea and electrolytes |
| Full blood Count |
| HDL cholesterol levels |
| Liver function Test |
| Urine Dipstick |

**Consider any necessary blood tests as stipulated in national guidelines**

**Please repeat bloods if patient requires them, including**

- Lithium and anti-epilepsy drug levels

- Vitamin D if on AED

- FSH in prolonger amenorrhoea

- PSA (if indicated)

- CRP (if indicated)

- Stool H Pylori (H Pylori is common in people with learning disabilities)

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| **MY MEDICINE - MEDICATION REVIEW** | | | | |
| Name | Dosage | What do you take it for? | Advised medication changes | |
|  |  |  |  | |
| Are you worried about any of your medication? | | | **Yes** | **No** |
| Do you take any over-the-counter medicines? (list here) \*Check contraindications with prescribed medication | | | **Yes** | **No** |

**Check that medication is being taken correctly e.g. with food**

**Consider medication reviews appropriate to the medication prescribed, including recommended health monitoring measures/checks**

Psychiatry or GP must review any patient taking more than 2 anti-psychotic medications prescribed for the management of behaviours that challenge (refer to Stopping the Over Medication in People with LD guidelines NHSE 2016)

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| **END OF LIFE CARE** | | |
| Has advanced care planning been considered? | **Yes** | **No** |
| Is patient on the gold standard framework? | **Yes** | **No** |
| Has the persons wishes been explored? | **Yes** | **No** |
| Patient’s wishes: | | |

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| **KEEPING SAFE: SAFEGUARDING** |
| Discuss and document any safeguarding concerns and what action will be taken  Is the patient under DOLS? |

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| ***Please remember to code Annual Health Check Activity.***   |  |  |  | | --- | --- | --- | |  | **EMIS** | **System One** | | **Learning Disability Annual Health Assessment** | **9HB5** | **XaL3Q** | | **Learning Disability Annual Health Assessment declined** | **9HB6** | **XaQnv** | | **Learning Disability Health Action Plan completed** | **9HB4** | **XaJsd** | | **Learning Disability Health Action Plan reviewed** | **9HB2** | **XaJWA** | | **Learning Disability Health Action Plan declined** | **9HB0** | **XaJW9** |   **On Learning Disability Register SNOMED- 416075005**  **Examination of learning disabled patient SNOMED- 442127005**  **Learning Disabilities Annual Health Assessment SNOMED199751000000100** |

**ACTIONS FROM MY HEALTH CHECK (Copy to be given to patient).  
  
YOUR NAME: DATE:**

|  |  |  |
| --- | --- | --- |
| BPwoman2 | Done by: |  |
| My Height: |  |
| My Weight: |  |
| My Blood Pressure: |  |
| Date for next Check: |  |
| GP1 | Do I need to see my doctor? When and why (*a blood test?)*: | |
| Diabetes_nurse1 | Do I need to see anyone else? (Who and Why): | |
| Social_worker2 | Health actions: (what, who and when) | |
| Dont_know_man2 | Anything else I need to know? | |