Important information for referrers

Before you complete the CDDH referral form, please read the following:

CDDH does not provide emergency or crisis care.
Should the person require urgent medical or psychiatric treatment, you should:

1. Contact the person's usual treating doctor and/or
2. Call 000 and ask for an ambulance and/or
3. Contact the local area Mental Health Service

CDDH Clinic

- CDDH clinics are for people aged 18 years and over, who have intellectual and associated developmental disabilities.
- CDDH provides clinical consultations to support the person's usual treating doctor to provide ongoing care.
- CDDH Clinic has GPs and does not have a psychiatry or psychology services.
- CDDH is not able to provide ongoing medical or psychiatric management.
- Complete pages 1-2, 4-10 of the referral form.

Disability Health Access Service (DHAS)

- DHAS is for people aged 18 years and over, with disabilities that require assistance to access preventative healthcare.
- DHAS provides preventative healthcare such as immunisations and blood tests and can assist with access to diagnostic imaging services.
- Complete pages 1-2, 11-13 of the referral form.

Monash Health

Centre for Developmental Disability Health
Referral Form

CDDH VICTORIA

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

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

Medical Treatment Decision Maker (MTDM)

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. **PLEASE TICK THE APPROPRIATE BOX:**

☐ The person's legally appointed medical treatment decision maker

☐ A guardian appointed by the Victorian Civil and Administrative Tribunal to make decisions about medical treatment for the person

☐ The first of the following people who is in a close and continuing relationship with the person:

- ◯ the person's spouse or domestic partner
- ◯ the person's primary carer *(Paid Disability Support Workers are NOT legally allowed to consent on behalf of the patient)*
- ◯ an adult child of the person
- ◯ a parent of the person
- ◯ an adult sibling of the person.

Note: Appointments made before the Medical Treatment Planning and Decisions Act commenced on 12 March 2018 are valid.

Name and relationship to patient:

Address:

Phone:

Email:

Has the MTDM been notified of the appointment?

◯ Yes ◯ No

If 'No', we ask that you notify the MTDM ASAP.

If there is a legally appointed Medical Treatment Decision Maker, or a VCAT Guardian, please provide us with documentation to confirm it.

Consent

For consultations, does the Medical Treatment Decision Maker consent to:

The referral for assessment by the Centre for Developmental Disability Health. **Yes** ◯ **No** ◯

An audit of the patient's file, if selected, for 'quality of care' review. **Yes** ◯ **No** ◯

*The sharing of relevant information to the following people involved in the person's care **(please tick the relevant boxes)**:*

General Practitioner	☐	Speech therapist	☐
Medical Treatment Decision Maker	☐	Physiotherapist	☐
House supervisor	☐	Medical specialist	☐
Behaviour Support Practitioner	☐	Day program coordinator	☐
Occupational Therapist	☐	NDIS Support Coordinator	☐

As part of the Centre's ongoing commitment to quality improvement, research, and innovation, we seek the consent for the use of our patient's de-identified general and demographic information collected through our service for future service and practice improvement. 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 patient and/or the MTDM consent to:

A collection of your (the patient's) personal and de-identified health information (e.g. primary diagnosis, medical history etc.)

Yes ◯ **No** ◯

Follow-up contact regarding your (or the patient's) experience in relation to the DHAS?

Yes ◯ **No** ◯

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 Healthcare 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.**

Reason for referral 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?	
Behaviour history 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.	
Are there any signs of physical illness? For example: • Reduced appetite • Change in bowel motions • Change in mobility • Loss of skills/function	
Is the person at risk of falls? **Is the person at risk of pressure injuries?**	Yes ○ No ○ Yes ○ No ○
Are there any signs of mental illness? For example: • Seeing and/or interacting with something that isn't there • Change to sleep pattern • Change to speech pattern • Change to mood	

Medical history Please tell us the person's medical history, including their height, weight, and any recent hospital admissions. **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.**	
Disability diagnosis • What is the formal diagnosis, if known (e.g. Cerebral Palsy, Autism Spectrum Disorder, Down Syndrome)? • If any, what is their degree of Intellectual Disability? • Have any genetic tests been performed, particularly in the last 5 years?	
How do they communicate? Please be specific e.g. verbal, gestures, facial expressions, communication device.	
What is their function in terms of…? • Mobility • Personal care (e.g. feeding, dressing, toileting) • Domestic tasks • Community tasks (e.g. money handling, taking public transport)	
Current health professionals involved 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.	
Family medical/psychiatric history	
Social history • Family relationships/involvement • Relationship with co-residents • Living arrangements, including client-to-carer ratio • Day activity (Which day program do they attend? How often do they go? Do they have 1:1 Disability Support Worker support?) • What does the person enjoy doing?	

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).

Role	**Name**	**Address**	**Phone**	**Email (or fax, if email is not available)**
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

MONASH University
Medicine, Nursing and Health Sciences

CDDH VICTORIA *Better Health Better Lives*

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 attemp	☐	☐
Depressed mood	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	☐	☐
Depressed thinking	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	☐	☐
Loss of interest/enjoyment in usual activities	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	☐	☐
Irritability	L	C
Irritable, short tempered	☐	☐
Temper tantrums	☐	☐
Verbally abusive	☐	☐
Physically threatening	☐	☐
Physical assault of others	☐	☐
Property damage	☐	☐
Anxiety	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	☐	☐
Social interaction and communication	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	☐	☐
General functioning	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	☐	☐
Appetite/ Weight	L	C
Loss of appetite, refusing food, picky with food	☐	☐
Loss of weight	☐	☐
Increased appetite	☐	☐
Increased weight	☐	☐
Sleep	L	C
Sleeping more or too much	☐	☐
Having trouble going to sleep, sleeping less, waking up during the night,	☐	☐
Waking up earlier than usual	☐	☐
Other behaviours	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 Referral Form

ELIGIBILITY FOR SERVICE

Is the person aged 18 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/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