ISP HEALTH PLANNING WORKSHEET

Massachusetts Department of Developmental Services

NAME: _____ **D.O.B.** _____

DATE Completed: _____
Completed by**:** _____
Relationship to Individual:____

From the past year, please list the number of: **Hospitalizations:** _____
Emergency Room visits: _____

Diagnosis/Conditions	Current Treatment/Effectiveness (including meds, treatment plans, treating clinicians, etc.)	Additional Supports Needed	Anticipated Future Needs
Fractures			
Infections			
a. Urinary Tract Infections (UTI)			
b. Pneumonia			
c. Other			
Major chronic condition causing significant decline			
Recently placed G/J tube or other implantable device			
Sudden, unexplained behavior changes			
Rapid decline in functional skills			

Diagnosis / Conditions	Current Treatment / Effectiveness (including meds, treatment plans, treating clinicians, etc.)	Additional Supports Needed	Anticipated Future Needs
Any other major health event in the past year			
Multiple episodes of choking			
Newly Diagnosed Conditions			
a. Diabetes			
b. Cancer			
c. Dementia			
d. Cardiac Condition			
e. Autoimmune Condition			
f. CVA (stroke)			
g. Dysphagia			
h. Other			

If any of the above diagnoses or conditions are present, has a clinical consultation been: Requested? ☐ Completed? ☐

Comments (indicate reason for request for clinical consultation/outcomes):