

Ohio Department of Developmental Disabilities

ISP HEALTH PLANNING WORKSHEET¹

DATE: _____

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

From the past year, please list the number of: <p align="right">HOSPITALIZATIONS: _____</p> <p align="right">EMERGENCY ROOM VISITS: _____</p>

Diagnosis/Conditions (LIST DATE OF OCCURANCE)	Current Treatment/Effectiveness (including meds, treatment plans, treating clinicians, etc.)	Current Supports Provided	Anticipated Future Needs (related to this condition or referred to a specialist)
Fractures			
Infections (in the past year):			
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			

¹ Adapted from the Massachusetts Department of MR

Diagnosis/Conditions	Current Treatment/Effectiveness (including meds, treatment plans, treating clinicians, etc.)	Additional Supports Needed	Anticipated Future Needs
Rapid decline in functional skills			
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			