IntellectAbility
REPLACING RISK WITH HEALTH AND WELLNESS

Acute Care Summary for People with IDD

To facilitate continuity of care, please complete the following questions in relation to this hospital stay, emergency department visit, hospital observation period, or other facility stay. This information is particularly important for people with intellectual and developmental disabilities (IDD) to assist in identifying health and safety risks and needed supports. Prior to returning to a person's home setting, the person must be in a stable and predictable condition where routine care can be safely provided by non-licensed supporters.

Today's date: _____ Facility name: _____

Person's name: _____ Date of birth: _____

Medication or food allergies/intolerances:

Date of emergency department visit: _____

Reason for visit:

Date of hospital admission: _____ Date of hospital discharge: _____

Admission diagnoses:

Discharge diagnoses:

Did the person spend time in ICU during this hospital stay? If so, what was the reason and treatment provided?

IntellectAbility
REPLACING RISK WITH HEALTH AND WELLNESS

Was the person on a ventilator during their hospital stay? If yes, include the number of days the person received mechanical ventilation.

Did the person have a "nothing by mouth" (NPO) order at any time? If so, why? Or did the person require any assistance with feeding themselves?

Did the person receive any nutrition and/or hydration other than by mouth? (Feeding tube, total parenteral nutrition (TPN), etc.)

Were any assistive devices used for mobility such as a wheelchair? (Do not include routine wheelchair use upon discharge. Complete only if needed due to change in mobility status.)

Was an in-and-out catheter or foley catheter used?

IntellectAbility
REPLACING RISK WITH HEALTH AND WELLNESS

Date of catheterization: _____ Date catheter was removed: _____

Did the person self-remove any IVs, tubes, or catheters or refuse medical treatment?

Were any behavioral supports required, such as wrist restraints, gloves/mittens, 1:1 sitter, etc.?

If so, why?

For how long were these interventions in place?

Date of last bowel movement: _____

Were any bowel aides used, such as a digital removal of an impaction or enema?

Were there any skin concerns such as bruising, rashes, cuts, redness, or pressure injuries?

IntellectAbility
REPLACING RISK WITH HEALTH AND WELLNESS

Were there any falls or near falls during the stay?

Any injuries during this stay? If so, what treatment was provided?

Was any speech, occupational, or physical therapy provided? If so, why?

Please provide the following medical records:
-All as-needed (PRN) and routine medications taken
-Vaccines given
-Treatments rendered (i.e. nebulizer treatments, CPT, ECT, and others)
-Lab results
-Findings of diagnostic procedures
-Surgical procedures
-Consults
-Emergency department notes
-History and physical
-Discharge summary

Please provide the following information related to follow-up care:
-Appointments/referrals
-Discharge diet orders
-New medication orders (including discontinued medications and/or dosage changes)
-Special orders (level of activity, assistive devices, etc.)

Name of person completing this information: _____

Contact number: _____

Thank you for providing this important information to assist with continuity of care.