**CARE AND TREATMENT REVIEWS**

**PHYSICAL HEALTH REVIEW**

***Please complete the following information in preparation for the care and treatment review for;***

**Name Date of CTR** 

|  | **RESPONSE** | **RECOMMENDATIONS** |
| --- | --- | --- |
| Is he/she registered with a GP |  |  |
| Has an annual health check been completed by the GP? |  |  |
| Are there care plans as a result of an annual health Check? |  |  |
| Are there any specific outstanding physical health needs?ConstipationPainDental careEye test/careHearing test/wax checksNutrition/weightSyndrome specific ExerciseContinence if relevantSleep hygienescreening |  |  |
| Are there any health professionals involved in his/her care? |  |  |
| other |  |  |
| Other |  |  |