

PARKINSON'S DISEASE DISCLOSURE

INSTRUCTIONS: This form must be reviewed with and signed by the resident/resident representative/guardian. Complete upon admission, quarterly, with a significant change of resident condition and upon the request of the resident/resident representative/guardian/facility.

_____ is committed in providing quality of care to all residents. For each
 (Facility Name)
 resident to receive and for _____ to provide the necessary care and services
 (Facility Name)

to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, it is necessary to build a team between the resident/resident representative/guardian, physicians and facility staff. Resident/resident representative/guardian participation in the management, treatment, interventions and approaches is an essential part of the overall care plan for the resident.

Parkinson's disease (PD) is a slowly progressive, degenerative neurological disorder of the central nervous system resulting in slow movement, muscle rigidity, postural instability and changes in cognition and mood. Parkinson's disease will worsen over time. Parkinson's itself is not fatal but disease complications can be fatal. Complications from PD is the 14th cause of death in the U.S. One million people in the U.S. have PD with about 600,000 people diagnosed each year. Men are 1.5 times more likely to have PD than women.

Parkinson's disease can complicate the diagnosis, clinical course and recovery from other illnesses.

***Note:** The pace at which Parkinson's disease progresses varies depending on the type, the person and physical/emotional stressors.

STAGE - CLINICAL SYMPTOMS

Stage I	<ul style="list-style-type: none"> • Infrequent blinking • Handwriting becomes smaller • Soft or lower voice • Deliberateness of speech • Lack of facial expression; mild changes with expressions • Mild symptoms that usually don't interfere with daily activities • Tremor on one side of the body; slight shaking of finger, thumb, chin. Tremor at rest is a common early symptom 	<ul style="list-style-type: none"> • Changes in posture • Changes in gait/walking
Stage II	<ul style="list-style-type: none"> • Symptoms start getting worse • Tremor and rigidity affect both sides of the body • Walking problems worsen • Poor posture becomes more apparent • Daily tasks become more difficult 	
Stage III (Mid-stage)	<ul style="list-style-type: none"> • Loss of balance • Lightheadedness • Falls are common • Vision problems • Movements are noticeably slower • Dressing and eating independently are significantly impaired • Constipation 	

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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STAGE - CLINICAL SYMPTOMS (Cont'd.)

Stage IV	<ul style="list-style-type: none"> • All symptoms from previous page are more severe and limiting • Pain • May require a walker or physical assistance for mobility • Usually unable to live alone at this stage - person needs help with activities of daily living • Sleep disorders • Incontinent of bowel and bladder • Weight loss • Loss of taste or smell
Stage V	<ul style="list-style-type: none"> • Most advanced and debilitating stage • Stiffness/rigidity in legs may make it impossible to stand or walk • Requires wheelchair; may be chair or bedridden • May experience hallucinations and/or delusions; cognitive changes which may include dementia • 24 hour care will be needed

Persons with Parkinson's Disease may develop complications that put them at risk for:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Falls • Aspiration pneumonia, choking • Infections • Urinary tract infections • Disuse syndrome – deterioration of body systems as the result of prescribed or unavoidable musculoskeletal inactivity • Pressure ulcers/injuries; frequent skin tears | <ul style="list-style-type: none"> • Weight loss • Death |
|--|--|

(*If not addressed in the plan of care: Specify resident condition, treatment options, expected outcomes, consequences of refusing treatment, resident's concerns, medications that may affect the disease process and offer relevant alternatives if the resident has refused treatment.)

Additional Comments:

NAME-Last	First	Middle	Attending Physician	Record No.	Room/Bed
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ACKNOWLEDGEMENT OF RECEIPT OF PARKINSON'S DISEASE DISCLOSURE

I, _____, acknowledge that I have received and reviewed a copy of
(Resident/Resident Representative/Guardian)

_____ Parkinson's Disease Disclosure which summarizes the clinical
(Facility Name)

symptoms a resident diagnosed with Parkinson's disease may exhibit. Residents diagnosed with Parkinson's disease may suffer from complications/adverse events and/or clinical symptoms that are a result of the natural progression of the disease process.

The Resident/Resident Representative/Guardian acknowledges that complications/adverse events may occur as a result of the disease process.

This facility recognizes the relationship between the Resident and the Resident Representative/Guardian is a critical element in identifying all of the resident's disease symptoms. The facility staff and physician requests that the Resident Representative/Guardian report all information regarding changes listed as clinical symptoms, complications or changes in the resident's usual behavior or status to the facility immediately.

I understand the facility will review this information with _____ when there
(Resident/Resident Representative/Guardian)

is a significant change of the resident's condition, quarterly and when requested by the Resident/Resident Representative/Guardian or Facility as a necessary part of the plan of care for the resident.

By signing, the Resident/Resident Representative/Guardian acknowledges the clinical symptoms and complications/risks associated with Parkinson's Disease, as well as the importance of participation in the overall plan of care for this resident.

ACKNOWLEDGEMENT SIGNATURES

Resident/Resident Representative/Guardian Date Signed _____

If signed by Resident Representative/Guardian, complete the following:

Print Name _____ Relationship _____

Person completing this form: _____
Signature and Title Date Signed _____

Witness signature: _____
Date Signed _____

NAME--Last	First	Middle	Attending Physician	Record No.	Room/Bed
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