



Name : .....

**PASSPORT - II**

ID No : .....

**Name of the clinic :**

.....

**Name :** .....

**ID No :** ..... **D.O.B :** ..... **M | F** .....

**Address:** .....

.....

.....

.....

**Phone No:** ..... (Primary contact)

**Phone No:** ..... (Secondary contact),

**Name of parent / guardian with relationship:** .....

.....

**Educational status:** .....

**Medical Insurance :**  yes  no

**if YES DETAILS:** .....

.....

## Contributors

### Dr. Surekha Ramachandran

Chairperson : Down Syndrome  
Federation of India  
Chairperson : Down Syndrome  
Association of Tamilnadu

### Dr. Shaji Thomas John

Chief of Paediatrics & Director  
Baby Memorial Hospital  
Calicut, Kerala  
Chairman - Down Syndrome Trust

### Dr. Suresh Seshadri

Director - Mediscan Systems, Chennai

### Dr. Sujatha Jagadeesh

Head - Department of Clinical Genetics  
Mediscan Systems, Chennai

### Dr. Bhavani Sriram

Consultant Pediatrician and Neonatologist  
Kinder clinic, Singapore  
Visiting Consultant  
K.K. Women and Children's Hospital, Singapore.

### Dr. Priya Biswakumar

Consultant Paediatrician  
Indira Child Care  
Down Syndrome Federation of India

**DOWN** SYNDROME  
**FEDERATION OF INDIA**

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Down Syndrome Federation of India & Mediscan Systems

# Medical Passport for Persons with Down Syndrome

## Annual evaluation:

- Routine adult healthcare
- Blood pressure monitoring
- Visual evaluation
- Dental evaluation
- ENT Evaluation every year and Auditory testing once in 2 years
- Clinical evaluation for functional abilities
- Evaluation for sleep apnea
- Neurological evaluation for early signs of dementia
- Look for Behavioural challenges and Psychiatry referral if needed
- Evaluate diet - Life style modification as required Low calorie, high fibre
- Regular exercise programme
- Reproductive counseling
- Hb /TSH / FT4 once in 5 years or earlier if needed.
- Screening for osteoporosis
- Screening for hypercholesterolemia
- HbA1c as required

Date: .....

Hospital of birth with place: ..... Country of origin: .....

**Diagnoses:** .....

Karyotype:  Non Disjunction  Translocation  Mosaic Date: .....

Details(pic upload if poss) .....

**Brief history:**

Antenatal / birth / development immunization status:

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.....  
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Family History & sibling history:

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Past history cardiac / thyroid / surgeries / hospitalization:

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Current medical issues and medication:

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.....  
.....  
.....

# Follow up visits (> 21 years)

Visit - 1

Date: .....

DD : MM : YY Haemoglobin: .....

Other tests:

.....  
.....  
.....

### Physical examination:

Weight: ..... kg Height: ..... cms. BMI: ..... Heart Rate: ..... BP: .....

General Examination: (Look for pallor, alopecia, cheilosis, dryness of skin)

VISUAL: .....

ENT .....

Dental .....

Remarks:

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.....

Systemic examination:

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Psychological issues:

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Brief summary of findings:

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Physical therapy / psychological counseling vocational guidance / occupational therapy

.....  
.....

Plan and follow up:

.....  
.....

# Follow up visits (> 21 years)

## Visit - 2

Date: .....

DD : MM : YY Haemoglobin: .....

Other tests:

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.....

### Physical examination:

Weight: ..... kg Height: ..... cms. BMI: ..... Heart Rate: ..... BP: .....

General Examination: (Look for pallor, alopecia, cheilosis, dryness of skin)

VISUAL: .....

ENT .....

Dental .....

Remarks:

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Systemic examination:

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Psychological issues:

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Brief summary of findings:

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.....

Physical therapy / psychological counseling vocational guidance / occupational therapy

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Plan and follow up:

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# Follow up visits (> 21 years)

Visit - 3

Date: .....

DD : MM : YY Haemoglobin: .....

Other tests:

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.....

**Physical examination:**

Weight: ..... kg Height: ..... cms. BMI: ..... Heart Rate: ..... BP: .....

General Examination: (Look for pallor, alopecia, cheilosis, dryness of skin)

VISUAL: .....

ENT .....

Dental .....

Remarks:

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Systemic examination:

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Psychological issues:

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Brief summary of findings:

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Physical therapy / psychological counseling vocational guidance / occupational therapy

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Plan and follow up:

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# Follow up visits (> 21 years)

Visit - 4

Date: .....

DD : MM : YY Haemoglobin: .....

Other tests:

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.....

**Physical examination:**

Weight: ..... kg Height: ..... cms. BMI: ..... Heart Rate: ..... BP: .....

General Examination: (Look for pallor, alopecia, cheilosis, dryness of skin)

VISUAL: .....

ENT .....

Dental .....

Remarks:

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Systemic examination:

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Psychological issues:

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Brief summary of findings:

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Physical therapy / psychological counseling vocational guidance / occupational therapy

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Plan and follow up:

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# Comments on compliance





## Doctor's contact details

Name : .....

Phone No: .....

Address: .....

.....

## Emergency contact details

### Doctor -1

Name : .....

Phone No: .....

Address: .....

.....

### Doctor -2

Name : .....

Phone No: .....

Address: .....

.....

### Doctor -3

Name : .....

Phone No: .....

Address: .....

.....

**Pd**  
own's syndrome  
passport

