

1: 10/15/2014

Medications

Allergies

VSD Signs

Bio-Medications

Procedures

Health Monitoring

Summary 2

Social History

Family Social History

Imaging

ICD

Problem Based Plan

Immunization

Physician Address

Care Plan

Dr. George Provder:

We had the pleasure of seeing your patient, Kevin Patient, for a consultation, per your request, in the Massachusetts General Hospital Down Syndrome Program, a multidisciplinary tertiary program that offers comprehensive clinical evaluation of children and adults with Down syndrome. As you know, Kevin is a 40 year old with Down syndrome, who is new to our clinic. Your patient was accompanied today by Mr. Stephen Brother, the patient's sibling.

In preparation for this clinical visit, I reviewed the patient's previous records along with our Program's intake form, completed by Mr. Stephen Brother, the patient's sibling.

During this visit, we addressed the following **CHIEF CONCERNS**

1. "increased anxiety and mood changes". The caregiver is "somewhat upset" about this issue.

**STRENGTHS**

Mr. Patient identified the following strengths: "Manners, kindness, knowledge of names".

**DIAGNOSIS**

We requested a copy of the original cytogenetic results for our records.

**PAST MEDICAL & SURGICAL HISTORY**

As you likely already know, this patient has a past medical history that is significant for the following conditions. I reviewed his previous medical records in order to gather part of this information.

1. Hypertonia, "Still a problem"
2. Obstructive sleep apnea, "Well-managed". Followed by Dr. Provder, last seen Sept 2014
3. Constipation, "Well-managed". Followed by Dr. Provder, last seen Sept 2014
4. Cognitive decline, "Still a problem"
5. Dry skin, "Well-managed"
6. Hair loss, "Well-managed"
7. Urinary retention, "Still a problem". Followed by Dr. Provder.
8. "Phychosex", "Well-managed". Followed by Dr. Smith.

Includes in note:  Vitals  Signature [E-mail](#) [Messages](#) [CC List](#)

[Print](#) [Email](#) [Cancel](#) [History](#)

**Figure S2b.** Clinical narratives automatically generated from the DS online intake, incorporating all relevant caregiver responses. The report is formatted as a consult letter to the referring primary care provider.