



- This Autonomic Dysreflexia Plan must be developed with the person we support and their Health Practitioner.
- The Autonomic Dysreflexia Plan must be overseen by the Health Practitioner.
- **Staff members must be appropriately trained to administer or dispense medication and undertake any Autonomic Dysreflexia Procedures.**
- This Autonomic Dysreflexia Plan should be read in conjunction with the relevant policies and procedures.

In the event of an emergency call an ambulance immediately on triple zero (000)

Personal Details <i>(to be completed by staff & person we support)</i>				
Name:		CIRTS ID:		
Date of Plan:		Review Date:		
Risks and Emergency Response				
Risks				
When to call an ambulance				
When to seek medical assistance				
My Support includes (tick all that apply) and who undertakes this:				
Procedure	Me	LWB DSW	Health Professional	Other
<input type="checkbox"/> Blood Pressure Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Emergency medication administration (refer to PRN Protocol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Bowel Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specific Autonomic Dysreflexia Information <i>(completed by a Health Professional)</i>				
Neurological location of Injury:				

Baseline Blood Pressure Rate of the person we support:			
Baseline Body Temperature of the person we support:			
Note regarding Blood Pressure:	20mm to 40mm Hg above baseline in adults may be a sign of Autonomic Dysreflexia	15mm to 20mm Hg above baseline in adolescents may be a sign of Autonomic Dysreflexia	15mm Hg above baseline in children may be a sign of Autonomic Dysreflexia

Common causes specific to me (Completed by Health Professional)	
<input type="checkbox"/> bladder can be blocked (urinary catheter) <input type="checkbox"/> kidney stones <input type="checkbox"/> urinary tract infection <input type="checkbox"/> constipation or administration of enema	<input type="checkbox"/> faecal impaction or administration of enema <input type="checkbox"/> pressure injuries <input type="checkbox"/> haemorrhoids <input type="checkbox"/> Other:
Symptoms and signs specific to me (Completed by Health Professional)	
<input type="checkbox"/> sudden hypertension (high blood pressure) <input type="checkbox"/> pounding headache <input type="checkbox"/> bradycardia (slow heart rate) <input type="checkbox"/> flushing or blotching of the skin above the level of the spinal cord injury <input type="checkbox"/> profuse sweating above the spinal cord injury level <input type="checkbox"/> sense of apprehension or anxiety	<input type="checkbox"/> shivering and chills with no temperature <input type="checkbox"/> nasal congestion <input type="checkbox"/> blurred vision <input type="checkbox"/> shortness of breath <input type="checkbox"/> pale skin tone and goose bumps below the level of spinal cord injury <input type="checkbox"/> irritability or change in behaviour
Checking Blood Pressure intervals (Completed by Health Professional)	
If symptoms persist, monitor Blood Pressure every _____ minutes and record on the NDIS LWB 5595 Blood Pressure Monitoring - Recording Chart .	
Administer Emergency Medication (Completed by Health Professional)	

Administer Emergency Medication as per the [NDIS LWB 5411 PRN Protocol](#) when Blood Pressure is at

Details about any specific changes or preferences staff must know in order to support the person with this plan: (Completed by the Health Professional)

☐ Not Applicable, the person's supports do not require any modification.

☐ Modifications are required as follows:

After calling an ambulance, call the following emergency contacts (Completed by the person we support or their support network):

Name:		Contact Number	
Relationship			
Name:		Contact Number	
Relationship			

Plan developed by: (completed by Health Professional(s))

Name:		Profession:	
Contact details:		Date:	
Name:		Profession:	
Contact details:		Date:	

Review of plan (completed by Health Professional)

<input type="checkbox"/> Set review:	Date:	
Signature:		
<input type="checkbox"/> As needed review: This plan will be reviewed following <ul style="list-style-type: none"> • a problem being identified while following this plan • a new risk being identified • advice from the person's GP/ Allied Health Professional 		

Consent and Authorisation

I consent to the support requirements detailed in this plan to be implemented to assist in the management of my health supports or receive general emergency response as required. If I am unable to give consent, LWB will seek consent from my guardian/person responsible.

Name	Relationship	Signature	Date
	Self		
	Guardian / Person Responsible		
	LWB Line Manager		

Upload to CIRTS as follows:

Plans & Assessments > New Plan > Service Type = the service providing the HIDPA > Plan name – [select from drop down] Autonomic Dysreflexia Management Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD