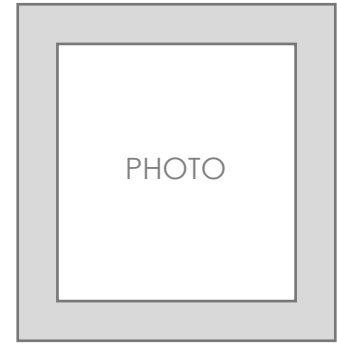




Date Completed:

**My
Health
Passport**



Please read this assessment to get to know me. It contains important information about me.

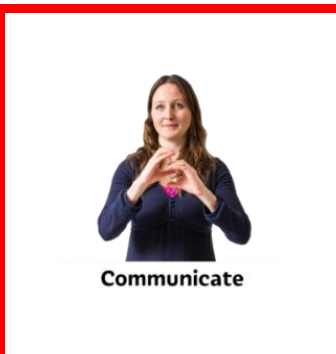


My name is

I like to be known as

This health passport belongs to me. Please return it when I am discharged.

FOR HOSPITAL ADMISSIONS: Please keep a copy of my health passport with my nursing file at the end of the bed. Please also inform the Hospital Liaison Nurses that I am here and record the date in my notes.

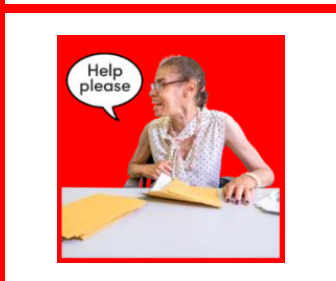


My preferred **communication method** to help me understand:-

✓ **tick boxes which apply**

- Speaking
- Signing
- Pictures
- Using objects
- Inform Others
- Easy Read

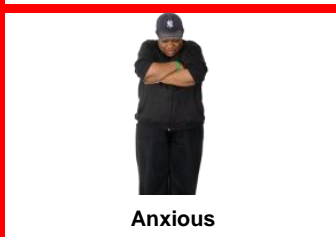
Other **communication methods** I find helpful:-




I have **difficulty** with:-

✓ **tick boxes which apply**




- Writing
- Self-care
- Moving
- Controlling my behaviour







How to help me if I am **anxious**:-

	My normal observations	Blood Pressure..... Pulse..... Temperature..... Breathing Rate.....
-----------------------------------------------------------------------------------	------------------------	------------------------------------------------------------------------------





Where I live and my main support

	<input type="checkbox"/> Living with family and friends <input type="checkbox"/> Privately rented <input type="checkbox"/> Supported accommodation	<input type="checkbox"/> Housing Association <input type="checkbox"/> Residential home <input type="checkbox"/> Nursing home	<input type="checkbox"/> One to one hours in 24 hrs <input type="checkbox"/> Shared care hours in 24 hrs <input type="checkbox"/> Other
	Who cares for me and relationship		
	Their telephone number		








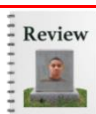
Next of Kin

	Name		
	Relationship (e.g. Mum)		
	Their address		
	Their telephone number		

Emergency or First Point of Contact

	Name		
	Relationship (e.g. Dad)		
	Their address		
	Their telephone number		

PERSONAL INFORMATION

	Do you have epilepsy?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have any allergies?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have heart problems?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have a lung problem? (e.g. respiratory)	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have diabetes?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have a feeding tube?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have a problem eating, drinking or swallowing?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>
	Do you have an End of Life plan?	✓ <input type="checkbox"/> or ✗ <input type="checkbox"/>

My Medical History:

for medically complex patients - see page 8

	
-------------------------------------------------------------------------------------	--

How I take my medication:




	<p>✓ tick boxes which apply</p> <p><input type="checkbox"/> With water <input type="checkbox"/> Crushed tablet <input type="checkbox"/> Injection</p> <p><input type="checkbox"/> Syrup <input type="checkbox"/> Dosette box <input type="checkbox"/> Blister packs</p> <p><input type="checkbox"/> Other</p>
-------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Medical Interventions:




how to take my blood, give injections, blood pressure, etc.

	
-------------------------------------------------------------------------------------	--

PERSONAL INFORMATION

	GP name	
	GP surgery	
	GP telephone number	

My contact details

	My Address	
	My telephone number	
	My email address	

Other services or professionals involved in my care (or nominated advocate)

 Please give name, job title and contact details ☎ for each service or professional or nominated advocate 	1.	
	2.	
	3.	
	4.	
	5.	

How will you know if I am in pain: e.g. verbally, facial expressions, pictures, noises

	
-------------------------------------------------------------------------------------	--

DAILY ACTIVITIES

	<p>Keeping safe e.g. bed rails, behaviour, managing equipment, running away</p>	
	<p>Level of support e.g. what level of support do you have at home</p>	
	<p>Support I need with dressing e.g. washing, special needs</p>	
	<p>Sight and hearing problems e.g. glasses, hearing aid</p>	
 Eat	<p>Support I need with eating e.g. food cut up, help required, special equipment, pureed food</p>	
 Drink	<p>Support I need with drinking e.g. ordinary cup or special equipment, small amounts, help required, thickened fluids</p>	
	<p>Going to the toilet e.g. help required to get to the toilet, continence aids – pad size</p>	
	<p>Help with moving around e.g. walking aids, hoist transfer</p>	
	<p>Sleeping e.g. posture in bed, sleep pattern, sleep routine, equipment required</p>	
	<p>Important routines</p>	
	<p>Religion, Cultural or Spiritual Needs</p>	



If a person is assessed as lacking the ability to make a decision and needing an advocate, please follow local Mental Capacity Act Policies and Mental Capacity Act Code of Practice.

If I am assessed as lacking the capacity to consent to my treatment, the following people must be involved in any decisions made in my best interest.

Name	Relationship	Contact Details

MY CURRENT MEDICATION LIST



Attach a copy of your current list of prescribed medication
e.g. MAR Chart or GP Repeat Prescription

LIKES AND DISLIKES



Things I like that make me happy, safe and comfortable
 e.g. things I like to do - watching TV, reading, music, leisure activities



Things I don't like that make me sad
 e.g. things that upset me - don't shout, physical touch, restraint



Food and drink I like



Food and drink I don't like





ME AT MY BEST

This is me on a good day e.g. body language, vocal signs, habits, eye contact, skin appearance



ADDITIONAL INFORMATION

Reasonable Adjustments or Special Needs

Updated by PALMS, part of Hertfordshire Community NHS Trust. Originally produced by the Learning Disability Health Facilitation Team 2020 following consultation with Learning Disability partners in Gloucestershire Hospital NHS Foundation Trust, All Disability Provider Forum and a county survey. Update based on the original work by the former Gloucestershire Partnership NHS Trust. Images courtesy of Photosymbols.