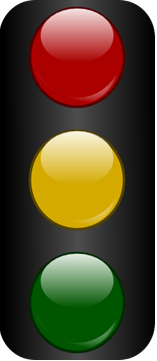


**Health Passport**

Supporting All My Health Needs

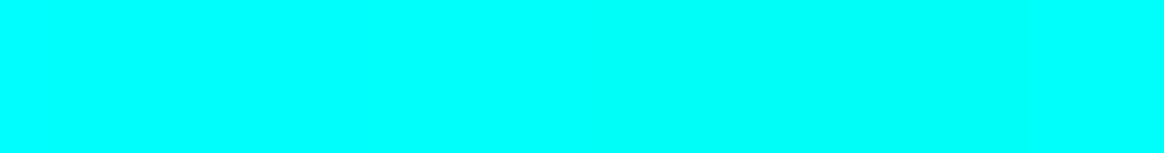
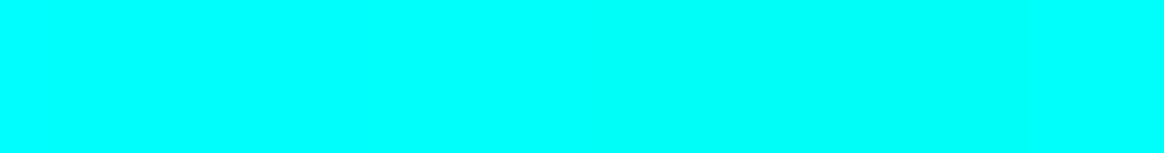


Name:...............................................................................................

Date of birth:...................................................................................................

NHS number:....................................................................................................

D number:.................................................................................................



***RDaSH*** *leading the way with care*

Please read the whole document and ask • me / • my family / • carers

*(Circle all relevant)*

Name: .................................................................................................

Prefers to be called: ............................................................................

Address: .............................................................................................

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

Contact Number: .................................. Next of kin: .................................

Emergency Contact details:

GP/ Surgery: ........................................... Tel Number:..............................

Any relevant information: *(please circle)*

Type 1 or Type 2 Diabetes • Regular Aspirin or blood thinners

(State name of drug)...................................................................................

Attach copy of recent Medicine Administration Record sheet or repeat request

Any known cognitive impairment, learning disability diagnosis, please add below

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

*(Circle all relevant)*

• I wear glasses • I wear hearing aid • Any prosthetics

Any history of MRSA, C.Diff or Carbapenem-resistant Enterobacteriaceae (CRE) – any current antibiotic therapy

Vaccine status: COVID .............................. Flu..................................

Others please add .....................................................................................

Allergies: ...................................................................................................

Urgent reasonable adjustments

1. ..........................................................................................................
2. ..........................................................................................................
3. ..........................................................................................................

Brief communication summary:

My first language is.....................................................................................

I speak well or I use …………………………………………to communicate

I can/ cannot read and write

|  |  |
| --- | --- |
| **A - Airway**  Are there any known airway issues, do they breathe independently? |  |
| **B - Breathing**  Any diagnosed breathing difficulties like asthma, cystic fibrosis, or COPD |  |
| **C - Circulation**  Are there problems with circulation for example hands/ feet are always purple? |  |
| **D - Disability**  What is the person’s diagnoses? How does the person communicate?  What is the person’s  normal mobility? |  |
| **E - Exposure**  We will need to remove clothing, is there anything we should know: |  |

Add anything below that will help with the initial assessment/ paramedics/A&E:

Is there a recent hospital discharge letter: please supply?

Is there a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) document:

(please tick): ■ YES ■ NO

Is (insert name ……………………………………………..) for resuscitation

(Please tick): ■ YES ■ NO

To be completed at time of request for ambulance or when going to A&E:

|  |  |
| --- | --- |
| **S - Situation** | What are you worried about most right now?  Any current infection such as Urinary Tract Infections (UTI) |
| **B - Background** | Why is this different from other days? How long has it been  going on for? |
| **A - Assessment** | Has the person been seen by anyone recently for this  problem? |
| **R - Recommendation** | Has this happened before? What worked well? |

Is there an Advanced Directive? ■ YES (please attach) ■ NO

Is there a lasting power of attorney for health and welfare?

■ YES, who is named and contact details: ...............................................

…………………………………………………………………………………...

■ NO

Things you must know about me:

Health conditions:

Heart (heart problems): ■ YES ■ NO

Breathing (Respiratory problems): ■ YES ■ NO

Epilepsy: ■ YES ■ NO

Going to the toilet (weeing or pooing).

*Please bring catheter passport if you have one*

How often do you normally poo and what is it like? – see Bristol Stool Chart on back page

Do you struggle with toilet needs ■ YES ■ NO

Gastric Disorders: ■ YES ■ NO

Eating and drinking issues: ■ YES ■ NO

Medical interventions – how to take my blood, give injections, take temperature, medication (how and who/what helps me), Blood Pressure etc:

|  |  |  |
| --- | --- | --- |
| **How I may present when in hospital or having medical interventions:** | | |
| **Activity** | **Usual/ baseline** | **Expected changes when unwell** |
| Going to the toilet or continence aids used |  |  |
| Eating including International Dysphagia Diet Standardisation Initiative (IDDSI) recommendation and utensils needed |  |  |
| Drinking including IDDSI recommendations and ability to use cup/ straw etc. |  |  |
| Moving around, level of support and any equipment required. Do they have bed sides are they likely to walk out of the hospital. |  |  |
| Communication i.e written, verbal, Makaton. How does the person express pain, hunger thirst |  |  |
| Personal care level of independence, how does the person manage in shower, could they strip wash independently. What support do they need to shave or brush teeth. |  |  |

|  |  |  |
| --- | --- | --- |
| Sleep, how many pillows, are they hot/cold normally What would be their usual sleep/ wake times |  |  |
| Does the person present with behaviour and what is the person trying to communicate |  |  |
| What level of support will this person receive from the family/ carers when in hospital |  |  |

How might I cope in hospital?

Please attach any other relevant plans.

|  |  |
| --- | --- |
| **Things that will help my stay in hospital** | |
| My likes (things I like to talk about) |  |
| My dislikes (triggers) |  |
| My needs/ wishes |  |
| Best approach to health interventions |  |

Discharge planning

I currently live in (explain the property i.e bungalow/ ground floor or house bedroom and bathroom on second floor) is there wheelchair access? Is it supported living care or nursing home?

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

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

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

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

Equipment I have in place at home (are all staff trained to use equipment?):

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

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

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

Technology I use at home..........................................................................

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

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

Response alarm: (please circle) • In house or • local authority

Current care package: i.e 24-hour care or 6 hours per day social care. Who provides care and what limitations to care provided i.e. no medication administration, no healthcare needs, or social care only.

Please state if no support: .........................................................................

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

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

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

Package: who funds this? .........................................................................

Care company/ home manager:.................................................................

Tel number: ..............................................................................................

Information sharing: please talk to family/ carer or nurse/ social worker/ community Learning Disability Team – involve in any best interest meeting:

Person ....................................................................................................

Role................................................ Tel No .............................................

Person ....................................................................................................

Role................................................ Tel No .............................................

Person ....................................................................................................

Role................................................ Tel No .............................................

Plan for me to get back home – do I need including or is it better to tell me when I am leaving.

Consider including Home Care Team and use a social story if circumstances are changing.

Referrals needed: (please circle) • inpatient or • outpatient

* Hospital Occupational Therapy/ Physiotherapy/ Speech and Language Therapy
* Learning Disability Hospital Liaison Nurse
* Integrated Discharge Team
* Independent Mental Capacity Advocates
* Social Worker
* Learning Disability Health Team and/ or Mental Health Team
* District Nurses GP
* Infection Prevention and Control (IPC) Team (Community) if discharged supported living or residential/ nursing care if IPC concerns

Previous hospital admissions:.................................................................

Previous hospital admissions:.................................................................

Reason for admission ..............................................................................

Date ..................................... Where/ which ward.....................................

Basic outcome ..........................................................................................

|  |  |  |  |
| --- | --- | --- | --- |
| **Previous hospital admissions** | | |  |
| Reason for admission | Date | Where/which ward | Basic outcome |
|  |  |  |  |
|  |  |  |  |

Health appointments

Record annual health check, optician, dentist, and health screening

I prefer my appointments to be (please circle):

• morning • afternoon • I don’t mind

I will have support from parents / carers at my appointment

■ YES ■ NO

I would like support from Learning Disability Ambassador or Learning Disability Liaison Nurse

■ YES ■ NO

In my appointment I may need …………………………………….. present

People who help me look after my care

Person ....................................................................................................

Role................................................ Tel No .............................................

Person ....................................................................................................

Role................................................ Tel No .............................................

Person ....................................................................................................

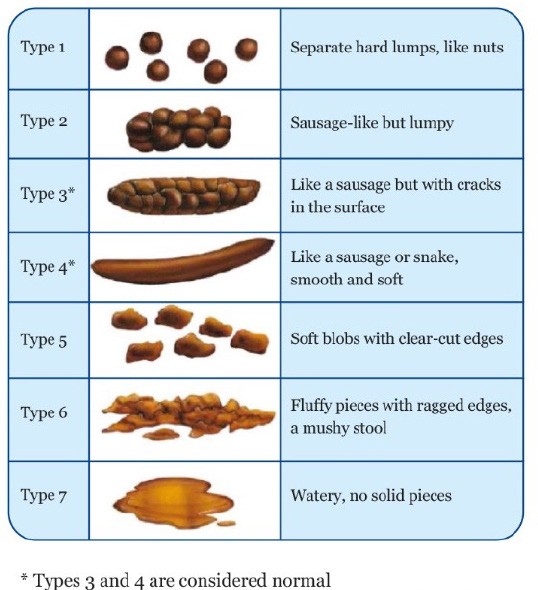
Role................................................ Tel No .............................................

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of appointment** | **Date** | **Where/which ward** | **Basic outcome** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Vaccination History

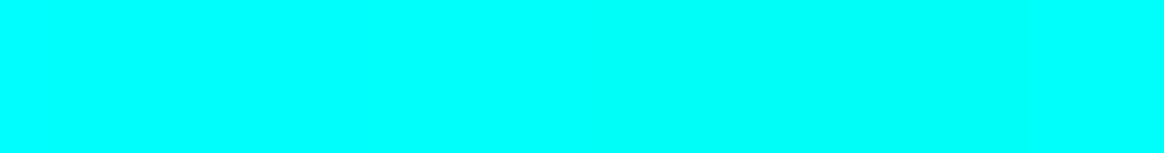
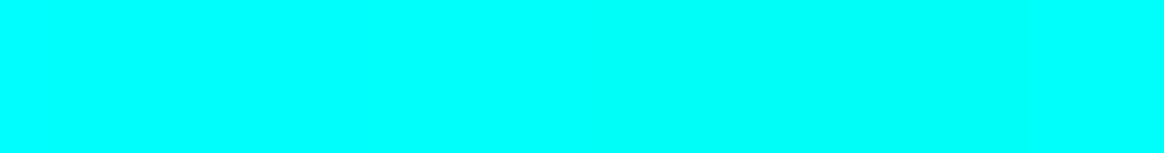
|  |  |  |  |
| --- | --- | --- | --- |
| Vaccine Name | Date Vaccine Given | Batch Number | GP/ Clinic/Other |
|  |  |  |  |
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|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

Bristol Stool Chart – for information



This information is correct at the time of publishing

Last Reviewed: November 2022



DP8827/11.22

*We are a smokefree organisation.* Please provide a smoke free environment for your healthcare provider

**get**