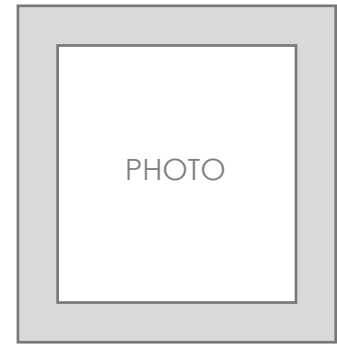




Date Completed:

**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.



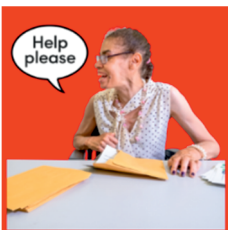
Communicate

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






Anxious

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





PERSONAL INFORMATION

| | | |
|---|------------------------|--|
|  | 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 <input type="checkbox"/> Syrup <input type="checkbox"/> Dosette box <input type="checkbox"/> Blister packs <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)

| | | |
|---|----|--|
| <div style="text-align: center;"></div> <p style="font-size: small;">Please give name, job title and contact details ☎ for each service or professional or nominated advocate</p> <div style="text-align: center;"></div> | 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> | |
|  <p style="text-align: center;">Eat</p> | <p>Support I need with eating e.g. food cut up, help required, special equipment, pureed food</p> | |
|  <p style="text-align: center;">Drink</p> | <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> | |

MENTAL CAPACITY ACT 2005 – FOR PEOPLE AGED 16 AND OVER



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

Download a copy of The Hospital Communication Book by visiting www.ghc.nhs.uk and searching for 'communication book'.

There are lots of Easy Read guides on these websites:

www.easyhealth.org.uk or www.apictureofhealth.southwest.nhs.uk

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.

Review: March 2021 (v Final)