

This Health Information Passport has been adapted and redeveloped by St Helens & Knowsley Learning Disability Specialist Practitioner August 2020. It is based on original work by Gloucestershire Foundation Trust. Widget Symbols © copyright Widget Software 2009

Health Passport

Nursing and Medical Staff please look at "My Health Passport" before you help me.

Reasonable Adjustments, please allow one person that, knows me well to accompany me within the Hospital (This Passport can be translated into different languages)

My name is:

I like to be known as:

DOB:

Hospital No:

Place your
Photograph here

Completed by:

Date:



Things you must know about me.

These things are important to me.

My likes and dislikes.

Author: Learning Disability Specialist Practitioner

Department: Safeguarding

Document Number: STHK1517

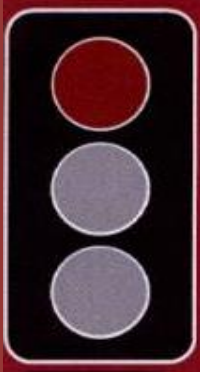
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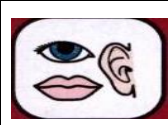
Name:

NHS:

DOB:



Things you must know about me...



How I communicate / what language I speak / how to communicate with me:



My Address:
Post Code:



My Contact Number:



Who I live with:
Family Co-tenants Supported Living Independent



My next of kin: Relationship (e.g. Mum, Dad, Friend)
Their Address:
Contact No:



My GP's Name Contact Number:
Their Address:



Other Services / Professionals involved with me:
Name: What is their role:
Contact Details



Allergy Alert:



Any Phobias:



My Height:	My Weight:	My BMI:
Date:	Date:	Date:








My Religion:	My Ethnicity:	My Religious needs:
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Name:
NHS:
DOB:

Reasonable Adjustments

Things you must know about me to support me safely...

	<p>What reasonable adjustments need to be put in place to support me?</p>
	<p>Medical Interventions : How to support me: e.g. blood pressure, taking bloods</p>
	<p>Health Conditions e.g. heart disease, diabetes, asthma, cancer, mental health (depression, anxiety, psychosis), gastro-intestinal problems. How this presents itself and how to support me.</p> <p>(Consent: Lead Professional is responsible to consider Mental Capacity Act if the person consent to treatment)</p>
	<p>My current medication: The dosage (how much) and tell us the form that it comes in e.g. tablets, liquid, injection, inhalers, creams. Do you have any problems with taking medication? e.g. side effects, allergies, difficulty swallowing etc. Any pain relief</p>
	<p>How you know I'm happy and content?</p> <p>How you know I am in pain?</p> <p>What signs do I show?</p>

Name:
NHS:
DOB:



My medical history and treatment plan: Include any previous admissions to hospital, or any previous operations. Details of any family medical history e.g. diabetes etc.



What to do if I'm anxious:

Also include:

- 1) Any triggers
- 2) How you know that I'm anxious
- 3) What to do when I'm anxious.



Mental Capacity Act and Advocacy.

Capacity needs to be assumed unless proven otherwise, if the person lacks capacity, capacity will need to be assessed by the health professional proposing the investigation and / or treatment.

Is there anyone who advocates for me? Yes No

Name: _____ (IMCA, N.O.K)

Contact details: _____

Does the person have a Health and Welfare Lasting Power of Attorney?

Yes No

Does the person have an Advanced Statement?

Yes No

Have you considered the need for a Best Interests Meeting? (MCA Document required)

Yes No

Have you involved the Community Learning Disability Team?

Yes No

- St Helens CLDT telephone number: 0151 426 5885
- Knowsley CLDT telephone number : 0151 426 5885
- Halton CLDT telephone number: 0151 511 6606
- Liverpool CLDT telephone number: 0151 330 7391



I wish for the information in this passport to be shared with:

GP Hospital Staff Family / Carers





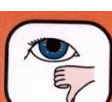

Other health professionals e.g. Dentist etc.

Anyone who the information cannot be shared with..... Please specify

Name:
NHS:
DOB:



Things you need to know about me ...

	How to help me understand things:
	Moving around (e.g. hoists, bed rails, wheelchair, walking aids, seating and slips / trips and falls, history of falls and how to support me)
	Personal care: (Dressing and Washing) and how to support me:
	Behaviour's that may challenge or behaviour that may cause risk (e.g. absconding and how to support me):
	Seeing / hearing any problems..... and how to support me:
	More information from: Name: _____ Contact Details: _____

Name:
NHS:
DOB:



How I eat food (cut up, risk of choking, helping with eating) and how to support me:
Positioning:(during meal times to reduce risks)



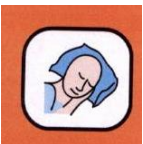
How I drink, swallow (small amounts, thickened fluids) and how to support me: Positioning:(during to reduce risks)



How I keep safe (support with behaviour that challenges, how long can I be left on my own, is there a need for 1-1 support) and how to support me:



How I use the toilet (wear pads, continence aids, promoting to use the toilet, physical support to get to the toilet, incontinent of urine and faeces etc.) and how to support me:



Sleeping (sleep pattern, routine, how long does person normally sleep, support to get to sleep, time goes to sleep / awakens normally) Does person need support at night for sleeping? How to support me:



Does the person have additional needs whilst in hospital e.g. behaviour that challenges, risk of absconding, lack of awareness of risk / danger (poor impulse control), postural care and support, all of the above needs, needs full support for activities of daily living.

If YES...

How will these needs be met and by whom?

Are additional resources required?

Name:
NHS:
DOB:

Things you should know about me...

Likes: for example – what makes me happy, what makes me feel safe, things I like to do

Dislikes: For example – don't shout, food I don't like, physical touch.

What's important to me?:
How to support me:
How I communicate?:
How to involve me?:
Important people in my life: Contact details

Things I like	Things I don't like
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Name:
NHS:
DOB:

Hospital Discharge / Information Plan

Name:

NHS No:

DOB:

Agreed discharge date:

Upon admission, consider discharge. Written communication with the following people or agencies as appropriate:

Family / Carers, GP

Community LD Team

Social Worker / Care Manager

Advocate

Discharge Planning Team

Other _____

Please Note Name and Contact Numbers

Discharge Plan Checklist

Do you have:

- Summary of what I have been treated for / diagnosed**
- Have my needs changed (e.g. PEG, swallowing, catheter, medication etc)**
- Is equipment needed? Who is providing it?**
- Do my family / carers / support staff need additional training**

Details: _____

Who will provide it?

- List of medication including any changes / additions. Do family / carers / support staff understand what medication is for? How to administer and and side effects?**
- Any follow up appointments?**
- Any other referrals required? To whom? _____**

Who will make the referral? _____

- Any infections / Pressure areas, who is managing these after discharge?**
- How am I getting home from hospital?**
- Please outline any action plan agreed / any other issues.**
- Who was involved in discharge planning, date of discharge planning meeting?**

Completed by:

Date:

Name:
NHS:
DOB: