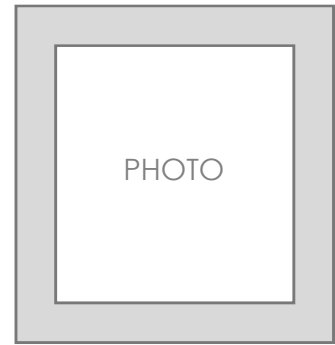




Date Completed: .....

**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**:-





## PERSONAL INFORMATION

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

	
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### How I take my medication:




	<p style="color: green; font-weight: bold;">✓ tick boxes which apply</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> With water</td> <td><input type="checkbox"/> Crushed tablet</td> <td><input type="checkbox"/> Injection</td> </tr> <tr> <td><input type="checkbox"/> Syrup</td> <td><input type="checkbox"/> Dosette box</td> <td><input type="checkbox"/> Blister packs</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> <td></td> </tr> </table>	<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		
<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										

### Medical Interventions:




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

	
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## 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

	
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## DAILY ACTIVITIES

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

<https://www.ghc.nhs.uk/files/Hospital%20Communication%20Book%20V2%202009.pdf>

There are lots of Easy Read guides on these websites:-

<http://www.easyhealth.org.uk/> or <http://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)