One Gloucestershire
Transforming Care, Transforming Communities

Date Completed:

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My Health Passport

PHOTO

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

My name is	
I like to be known as	
My DOB and NHS no.	

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:-

What **reasonable adjustments** I require in hospital.


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			
	☐ Living with family and friends ☐ In my own house or flat ☐ Supported accommodation	☐ Housing Association ☐ Residential home ☐ Nursing home	☐ One to one hours in 24 hrs ☐ Shared care hours in 24 hrs ☐ Other
	Who cares for me and relationship		
	Their telephone number		
Next of Kin (this is your closest family member)			
	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

	I have epilepsy	✘ ☐ or ✓ ☐	◯ epileptic and / or ◯ non-epileptic attacks
	I have allergies	✘ ☐ or ✓ ☐	
	I have heart problems	✘ ☐ or ✓ ☐	
	I have breathing problems	✘ ☐ or ✓ ☐ (e.g. respiratory)	
	I have diabetes	✘ ☐ or ✓ ☐	◯ Type 1 or ◯ Type 2
	I have a feeding tube	✘ ☐ or ✓ ☐	
	I have a problem eating, drinking or swallowing	✘ ☐ or ✓ ☐	
	Do you have an End of Life plan?	✘ ☐ or ✓ ☐	

My Medical History:

for medically complex patients - see page 8

How I take my medication:

✓ tick boxes which apply

- ☐ With water
- ☐ Liquid
- ☐ Other
- ☐ Crushed tablet
- ☐ Dosette box
- ☐ Injection
- ☐ Blister packs

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

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

I have difficulty with: ✓ **tick boxes which apply**

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

ADDITIONAL INFORMATION

Reasonable Adjustments or Special / Sensory Needs

ReSPECT — Making a Recommended Summary Plan for Emergency Care & Treatment (ReSPECT)

The ReSPECT form is a short plan about what should happen if you need health care or treatment in an emergency. Understanding what matters most in your life helps to make a better plan.

Do you have a ReSPECT form? ☐ **Yes** ☐ **No**

For ReSPECT Easy Read Guides: https://www.resus.org.uk/respect/respect-resources
For ReSPECT films: https://www.resus.org.uk/respect/respect-patients-and-carers

To download a copy of The Hospital Communication Book: visit www.ghc.nhs.uk then search 'Hospital Communication Book'

There are lots of Easy Read guides about health on: - 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.

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