



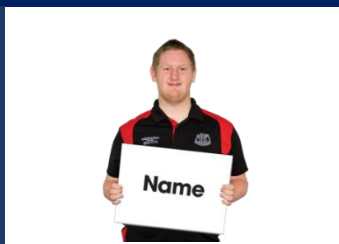
Date Completed:

.....

<b>My</b>
<b>Health</b>
<b>Passport</b>

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.

 <p><b>Communicate</b></p>	<p>My preferred <b>communication method</b> to help me understand:-</p> <p>✓ <b>tick boxes which apply</b></p> <table> <tr> <td><input type="checkbox"/> Speaking</td> <td><input type="checkbox"/> Signing</td> <td><input type="checkbox"/> Pictures</td> </tr> <tr> <td><input type="checkbox"/> Using objects</td> <td><input type="checkbox"/> Inform Others</td> <td><input type="checkbox"/> Easy Read</td> </tr> </table> <p>Other communication methods I find helpful:-</p>	<input type="checkbox"/> Speaking	<input type="checkbox"/> Signing	<input type="checkbox"/> Pictures	<input type="checkbox"/> Using objects	<input type="checkbox"/> Inform Others	<input type="checkbox"/> Easy Read
<input type="checkbox"/> Speaking	<input type="checkbox"/> Signing	<input type="checkbox"/> Pictures					
<input type="checkbox"/> Using objects	<input type="checkbox"/> Inform Others	<input type="checkbox"/> Easy Read					
	<p>What <b>reasonable adjustments</b> I require in hospital. </p>						
 <p><b>Anxious</b></p>	<p>How to help me if I am <b>anxious</b>.</p>						





## 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"/> In my own house or flat <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 (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	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	<input type="checkbox"/> epileptic and / or <input type="checkbox"/> non-epileptic attacks
	I have allergies	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	
	I have heart problems	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	
	I have breathing problems (e.g. respiratory)	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	
	I have diabetes	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	<input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2
	I have a feeding tube	✗ <input type="checkbox"/> or ✓ <input type="checkbox"/>	
	I 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:




	✓ <b>tick boxes which apply</b> <input type="checkbox"/> With water <input type="checkbox"/> Crushed tablet <input type="checkbox"/> Injection <input type="checkbox"/> Liquid <input type="checkbox"/> Dosette box <input type="checkbox"/> Blister packs <input type="checkbox"/> Other
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### 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

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

## 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



**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](http://www.ghc.nhs.uk) then search 'Hospital Communication Book'**

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

**[www.easyhealth.org.uk](http://www.easyhealth.org.uk) or [www.apictureofhealth.southwest.nhs.uk](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.

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