




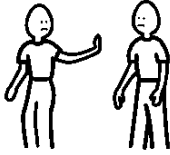


















I have something to say

		
I am OK	I am ready	I am not ready
		
I need help	I don't understand	Leave me alone
		
I am bored	I am sad	I am worried
		
I am angry	I am confused	I don't know

How do I feel..

	
headache	earache
	
stomach pain	back pain
	
chest pain	bottom pain
	
cold	be sick
	
fever	dizzy



Information about me if I get admitted to hospital.

I have a hospital passport. *(Please tick)*

Yes No

It is kept

I also have the following careplans/passports that are important to me.

Name of careplan/passport	Staff name and team	Where it is kept



Information about me if I get admitted to hospital.

My careplans/passports (continued)

Name of careplan/passports	Staff name and team	Where it is kept

To give consent for treatment



- Consent means agreeing to something.
- Before a doctor or nurse can examine or treat you they must ask you if you agree.
- You can say 'yes' or 'no'.

Treatment

- Treatment is something that a doctor or nurse gives you to make you better.
- Treatment might be an injection, medicine, an operation or getting treatment from a dentist.

You can ask questions before you give your consent to have treatment. For example:

- You can ask why you need to have something done.
- You can ask what will happen.
- You can ask how it will help you.
- You can ask what might go wrong.
- You can ask if something else can be done instead.
- You can ask what might happen if you refuse to have treatment.
- You can ask for more time to think about it.

- You can ask if you will have to pay.
- You can ask the name of the doctor who will look after you.

Your rights

- You have a right to have your say about your health care and treatment.
- You have a right to ask someone you know well to speak for you.
- You have a right to ask questions if you do not understand anything.
- You have a right to change your mind
- You have a right to say no to any treatment.
- You can have someone else with you when a doctor or nurse examines you.
- You do not have to be examined or treated by a student.
- You can ask for another doctor to see you.

You can give your consent in different ways:

- You can **say** you are happy to consent.
- You can **sign** a form.
- You can **show** by using a thumbs up or down.
- You can **point** to a picture to show what you think.



My support plan

Completed by (relationship)

.....Date.....

When I am well I will:

-
-
-

Things that could change my behaviour:

-
-
-

When I am upset or not well I will:

-
-
-

How to help me:

-
-
-



My support plan

Completed by (relationship)

.....Date.....

When I am well I will:

-
-
-

Things that could change my behaviour:

-
-
-

When I am upset or not well I will:

-
-
-

How to help me:

-
-
-

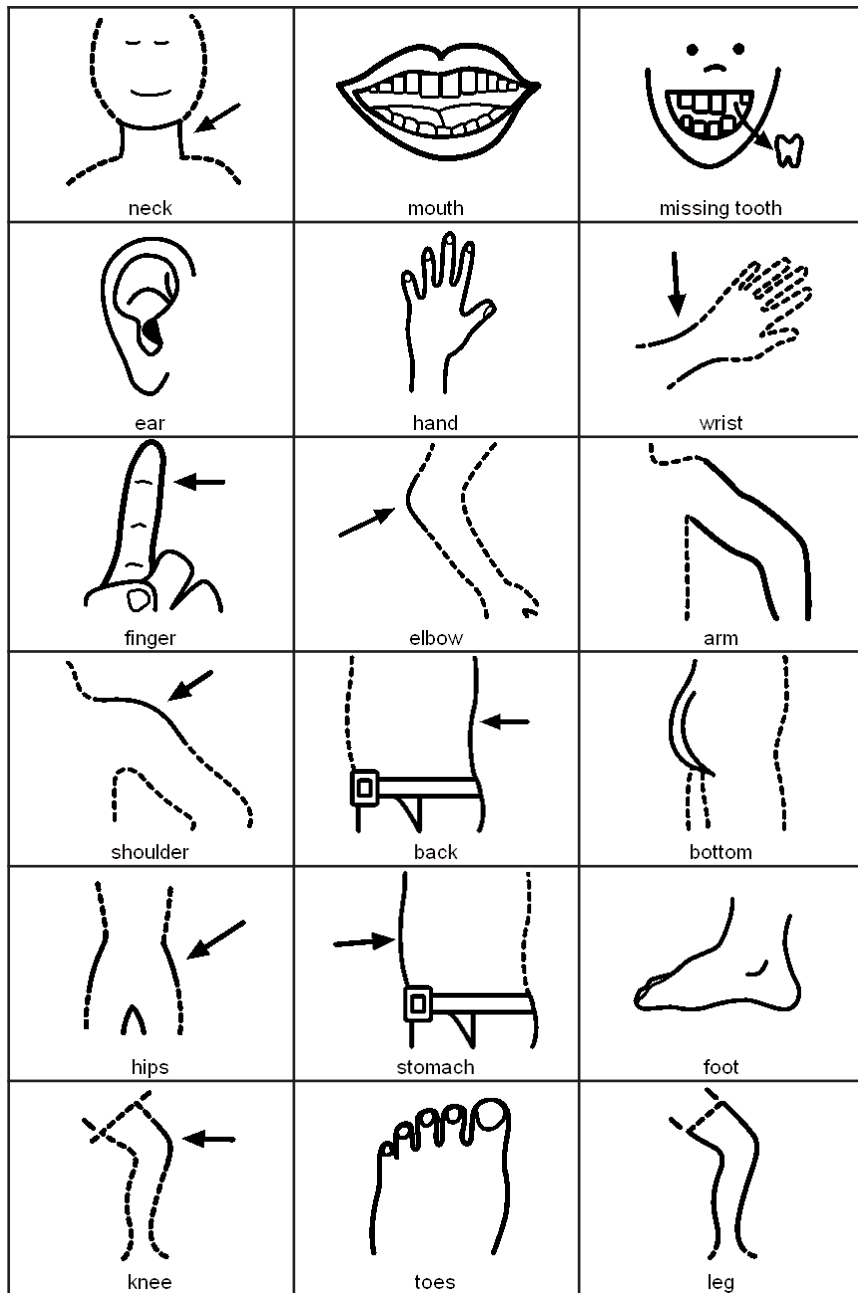
Other important people/organisations to contact

Name of person and organisation	Address and telephone number

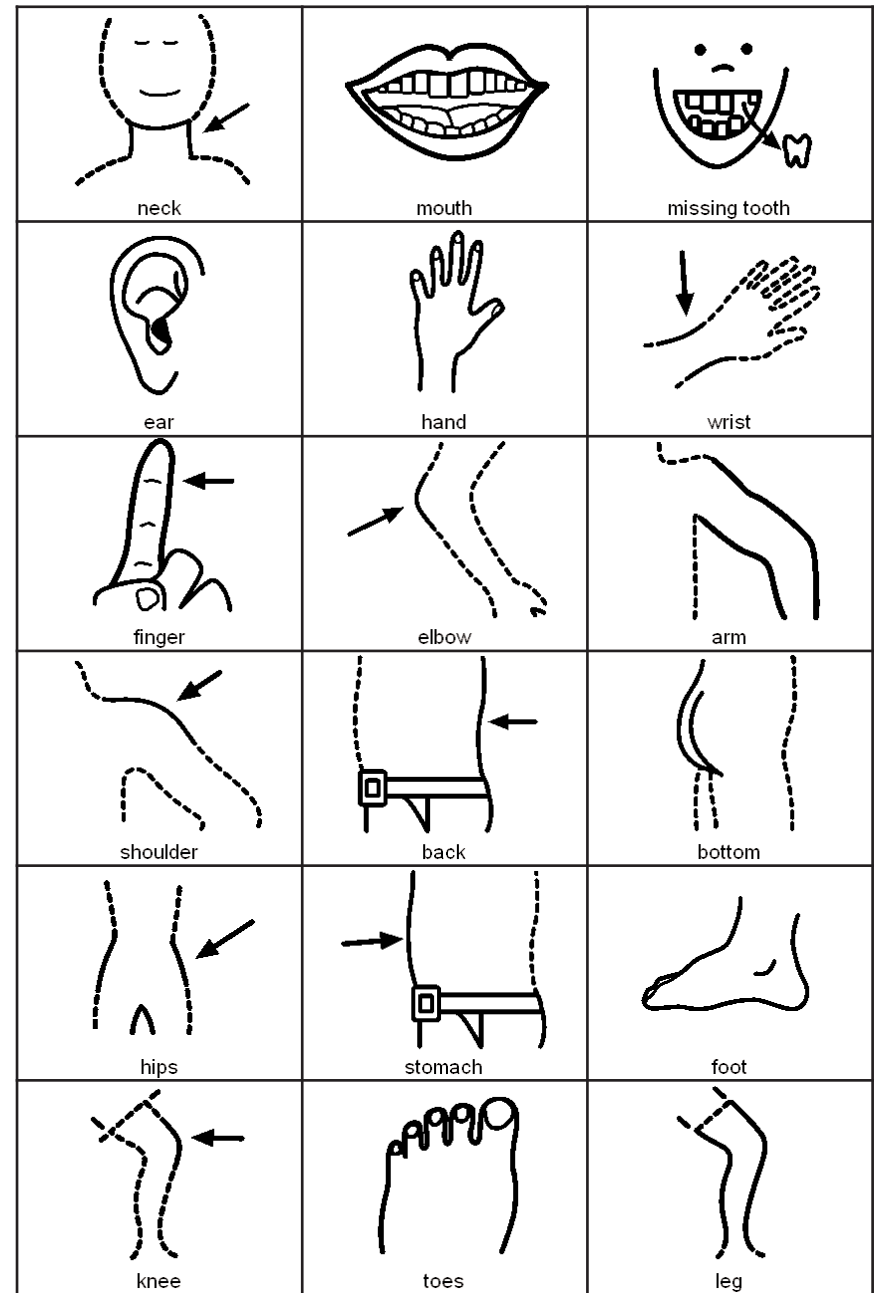
Other important people/organisations to contact

Name of person and organisation	Address and telephone number

Parts of the body



Parts of the body





People who are important to me

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....



People who are important to me

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

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Name.....Tel no.....

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Date started.....Date ended.....



People who are important to me

Name.....Tel no.....

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People who are important to me

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

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How they help me.....

Date started.....Date ended.....

Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

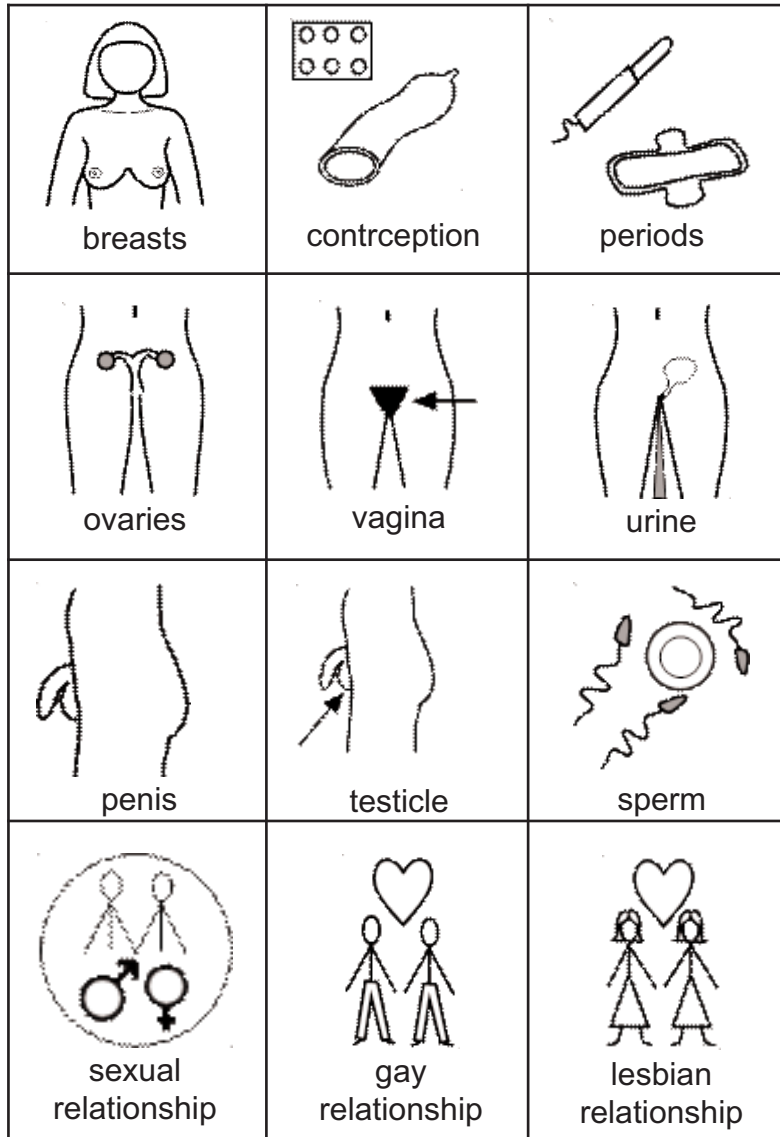
Name.....Tel no.....

How they help me.....

Date started.....Date ended.....

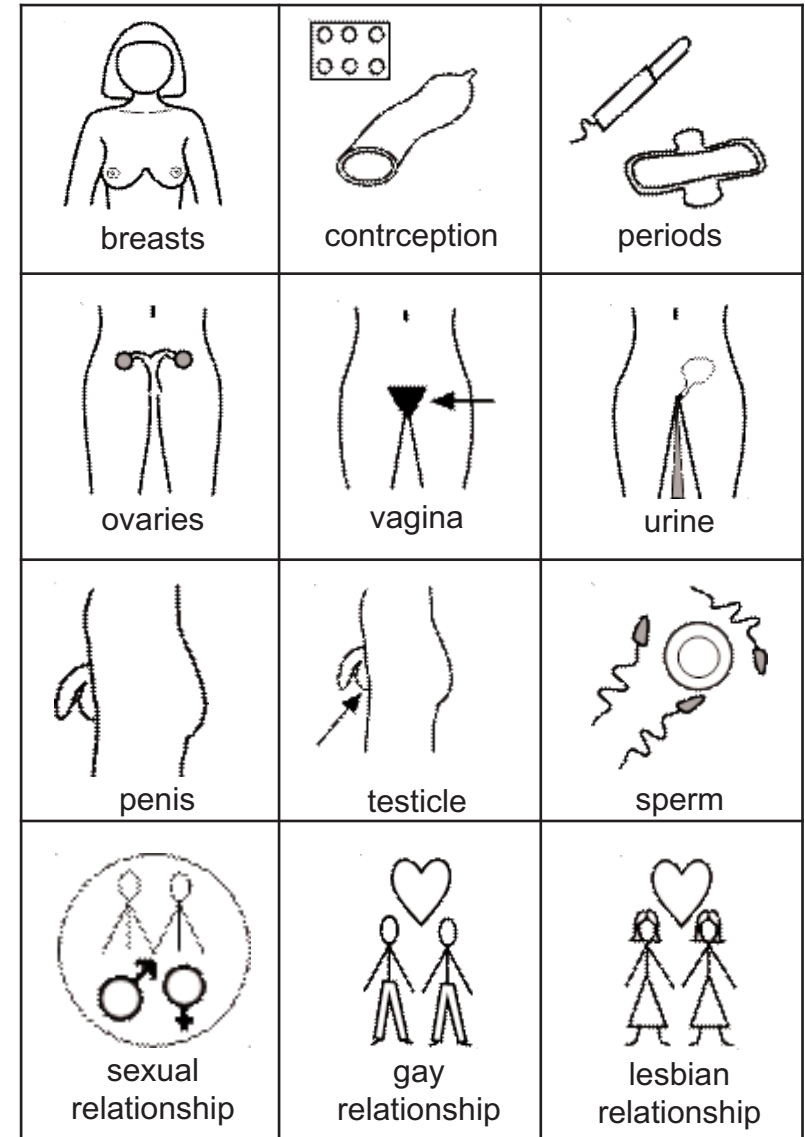
Private health issues

This communication board can be used for health appointments or discussing sex education



Private health issues

This communication board can be used for health appointments or discussing sex education





**Medicines record -
Tablets or liquids that do not
make me feel better**

Name	Side effects



**Medicines record -
Tablets or liquids that do not
make me feel better**

Name	Side effects



My medicines

(Please print)

Medication name and what it is for. State if blood test is needed	When I will take it	Date started & doctor signature	Date stopped & doctor signature



My medicines

(Please print)

Medication name and what it is for. State if blood test is needed	When I will take it	Date started & doctor signature	Date stopped & doctor signature



Ears

Completed by (relationship)
..... Date.....

(Please tick box)

I do not have problems with my hearing.

I do have problems with my hearing.

The details of my problem(s) are:

.....
.....

I (or others) have been concerned about my hearing because

.....
.....

I have had my hearing tested.
It would be easier to have my ears tested if:

.....
.....

I have a hearing aid. It helps/does not help my hearing *(delete as appropriate)*.

.....
.....

Update page

Date	What has changed	Name / job



Eating and drinking

Completed by (relationship)

.....Date.....

I have problems eating and drinking

I need a modified diet

Details (pureed, mashed, chopped):

.....
.....

I need my fluids thickened

Details:

.....
.....

I need a special diet for medical or personal reasons:

Diabetic Gluten free Low fat

High fibre Vegetarian Soft foods

Warning signs

If I gag, cough, choke or sound very gurgly, do not put more food and drink in my mouth. Stop and wait until my mouth is empty and I am breathing normally again. If these problems continue it is important to contact a speech and language therapist.



Eating and drinking

Completed by (relationship)

.....Date.....

I can feed myself

I need the following special equipment and/or prompts

.....
.....
.....

I can have a drink on my own

I need the following special equipment and/or prompts

.....
.....
.....

I need help with eating and drinking

I need the following special equipment and/or prompts

.....
.....
.....

Please record health action plans from page 72 and appointments from page 107.



Epilepsy

Completed by (relationship)

.....Date.....

This is what happens:

.....
.....
.....

I know I am going to have a fit when:

.....
.....
.....
.....

This is the help I need:

Before:

.....

During:

.....

After:.....

.....

.....

In an emergency this is what you need to know about my medicines and how it is given:

.....
.....
.....
.....

Medication details are recorded in the 'Medication' section (from page 29) YES/NO

People involved in my care are:

.....
.....
.....
.....

I have/have not had a EEG or other investigation.

(Delete as appropriate) Details:

.....
.....
.....
.....

Please record health action plans from page 72 and appointments from page 107.



Eyes

Completed by (relationship)

..... Date.....

(Please tick box)

I do not have problems with my sight.

I do have problems with my sight.

The details of my problem(s) are:

Please include conditions like glaucoma, cataract.

.....

.....

.....

.....

I am registered blind or partially blind

I wear glasses or contact lenses

I have my eyes checked regularly

The optician can help me with eye checks by:

.....

.....

Eye test results

Optometrist/Optician name	Practice name and address
Date	Signed

	Unaided Vision	Sph	Cyl	Axis	Prism	VA	Unaided Vision	Sph	Cyl	Axis	Prism	VA
Dist												
Near												

Acuity method or description of functional vision	
Right	Left

Glasses needed: Yes/No

Distance (TV and walking around): Yes/No To be worn all the time: Yes/No

Near (eating and close tasks): Yes/No Bifocal or Multifocal: Yes/No

Comments:

.....

.....

Other problems with eyes (lazy eye, squint, cataract, nystagmus (wobbly eye), keratoconus, glaucoma:

.....

.....

Advice on eyes and vision

.....

.....



Hand and foot care

Completed by (relationship)

..... Date.....

(Please tick box)

- I need help with my fingernail care.
- I need help with my toenail care.
- I have pain or discomfort in my feet.
- I wear made to measure shoes

Details of the above:

.....

.....

.....

I have special hand or foot requirements
(e.g. circulation, oedema). Please give details:

.....

.....

Other details:

.....

.....

.....

Update page

Date	What has changed	Name / job



Men's health and well being

Completed by (relationship)
..... Date.....

(Please tick box)

- I have been shown how to check for lumps in my testicles or around my penis
- I have been given advice about men's health (e.g. prostate/testicular cancer)
- I have been given information/advice about safe sex and contraception

The help I need to attend appointments involving intimate personal examination is:

.....

.....

.....

.....

.....

.....

.....

.....

.....

..



My well being and safety

Completed by (relationship)
..... Date.....

Everyone should be treated with respect and feel safe.

If any of these things have happened to you this is abuse:

- if someone touches your body or private parts in ways you do not like or want.
- people say bad things to hurt your feelings, shout or threaten you.
- if someone hurts you.
- if someone takes your money or belongings without asking.
- when people who are there to help you do not look after you properly.

If any of these has happened to you must tell someone you know well and can trust. They will make sure you get the right help.

Things that have happened to me:

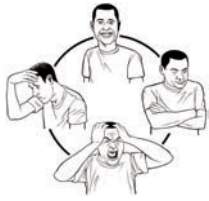
.....

.....

.....

.....

Please refer to communication board 'Private health issues' if needed



Mental health and behaviour

Completed by (relationship)

.....Date.....

Please tick

I have problems with my mental health /
behaviour that worry me and other people.

These problems are:

.....
.....
.....

My main worries and anxieties are:

.....
.....
.....

The risks that these problems can cause for myself or
others include:

.....
.....
.....
.....

The problems I have include:

(Please tick box and describe)

Details of problems

sleep

.....

eating/drinking

.....

behaviour.....

.....

mood

.....

confusion/memory problems

.....

activities/routines

.....

other (e.g. weight)

.....

.....

.....

.....

.....

.....



Other long term conditions

Completed by (relationship)

.....Date.....

I have the following long term condition:

(For example Diabetes, Sickle cell anaemia, Asthma, Cancer)

.....

This is help I am getting:

.....
.....
.....
.....
.....

When I feel unwell, this is the help I need:

Before:

.....

During:

.....

After:.....

.....

.....

In an emergency this is what you need to know about my medication and how it is given:

.....
.....
.....
.....

Medication details are recorded in the 'Medication' section (from page 29) YES/NO

People involved in my care are:

.....
.....
.....
.....

Any other information

.....
.....
.....
.....
.....

Please record health action plans from page 72 and appointments from page 107.



Information about my physical disability

Completed by (relationship)

..... Date.....

I have problems with the following:

<input type="checkbox"/>	my arms & hands	
<input type="checkbox"/>	my legs & feet	
<input type="checkbox"/>	my spine	
<input type="checkbox"/>	my face	
<input type="checkbox"/>	my neck	
<input type="checkbox"/>	other	

These problems affect me by:

.....

.....

.....

.....

.....

.....



Mobility and equipment

Completed by (relationship)

.....Date.....

I require the regular use of:

equipment	
<input type="checkbox"/> wheelchair	
<input type="checkbox"/> specialist seating	
<input type="checkbox"/> hoist	
<input type="checkbox"/> standing frame	
<input type="checkbox"/> foot straps	
<input type="checkbox"/> wrist straps	
<input type="checkbox"/> wedges	
<input type="checkbox"/> helmet	
<input type="checkbox"/> splints	
<input type="checkbox"/> oxygen	
<input type="checkbox"/> suction	
<input type="checkbox"/> tube feeding	
<input type="checkbox"/> cutlery	
<input type="checkbox"/> other (please state)	

Please record health action plans from page 72 and appointments from page 107.



Relationships

(Please tick box and describe)

I would like to have someone to chat to.
Ways to help me:

.....
.....
.....
.....

I would like to make friends.
Ways to help me:

.....
.....
.....
.....
.....

I would like to have a boy/girl friend.
Ways to meet someone:

.....
.....
.....
.....

Update page

Date	What has changed	Name / job

Your community learning disability team (CLDT) may be able to help you with the following:

 <p>writing your careplan</p>	 <p>healthy eating</p>	 <p>your health checks</p>
 <p>your black book</p>	 <p>your feelings</p>	 <p>your communication</p>
 <p>relationships</p>	 <p>your medicine</p>	 <p>looking after yourself</p>
 <p>eating and drinking</p>	 <p>moving around</p>	 <p>your illness</p>
 <p>going to hospital</p>	 <p>speaking up</p>	 <p>easy read information</p>

Your community learning disability team (CLDT) may be able to help you with the following:

 <p>writing your careplan</p>	 <p>healthy eating</p>	 <p>your health checks</p>
 <p>your black book</p>	 <p>your feelings</p>	 <p>your communication</p>
 <p>relationships</p>	 <p>your medicine</p>	 <p>looking after yourself</p>
 <p>eating and drinking</p>	 <p>moving around</p>	 <p>your illness</p>
 <p>going to hospital</p>	 <p>speaking up</p>	 <p>easy read information</p>



Women's health and well being

Completed by (relationship)
..... Date.....

(Please tick box)

- I do attend a well women clinic
- I have been shown how to check my breast for lumps, and changes in shape.
- There is a history of breast cancer in my family.

Please give family details

.....
.....

- I have problems with my periods. They are:

.....
.....

- I have been given information/advice on safe sex, contraception and women's health

- History of pregnancy/terminations

Details

.....
.....
.....
.....
.....



My well being and safety

Completed by (relationship)
..... Date.....

Everyone should be treated with respect and feel safe.

If any of these things have happened to you this is abuse:

- if someone touches your body or private parts in ways you do not like or want.
- people say bad things to hurt your feelings, shout or threaten you.
- if someone hurts you.
- if someone takes your money or belongings without asking.
- when people who are there to help you do not look after you properly.

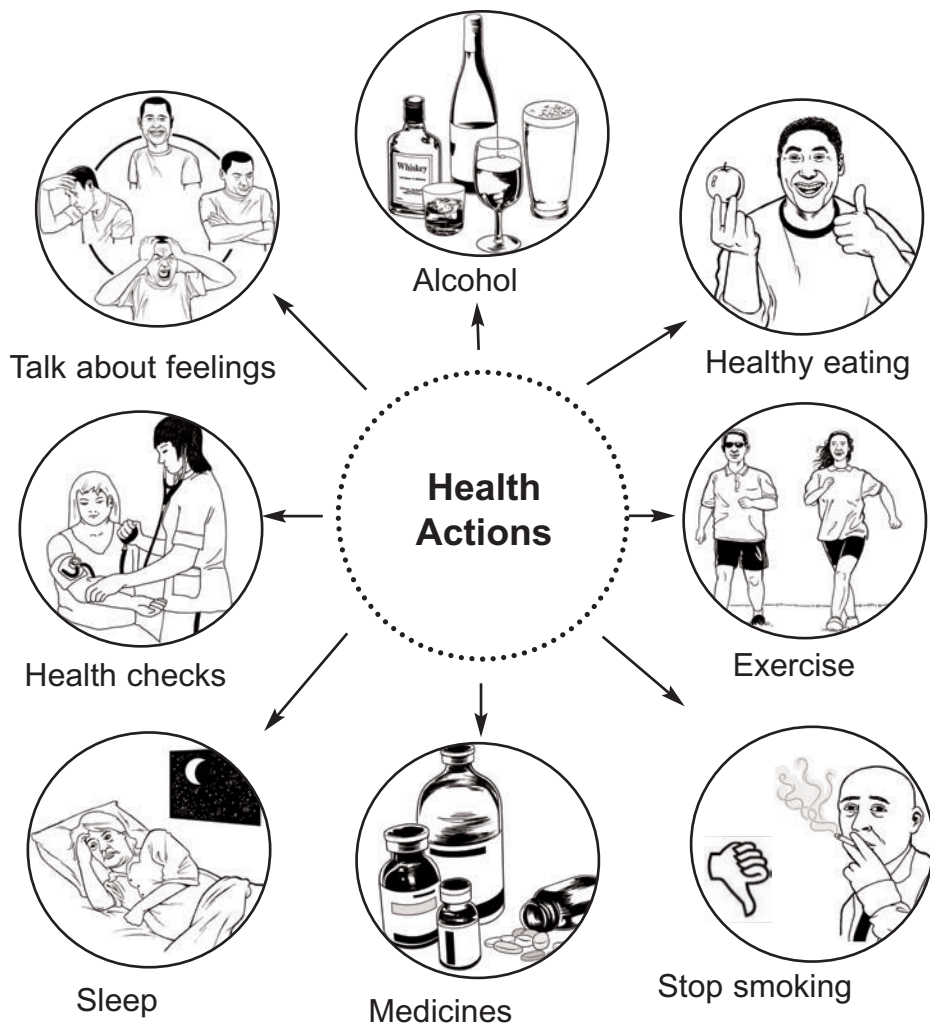
If any of these has happened to you must tell someone you know well and can trust. They will make sure you get the right help.

Things that have happened to me:

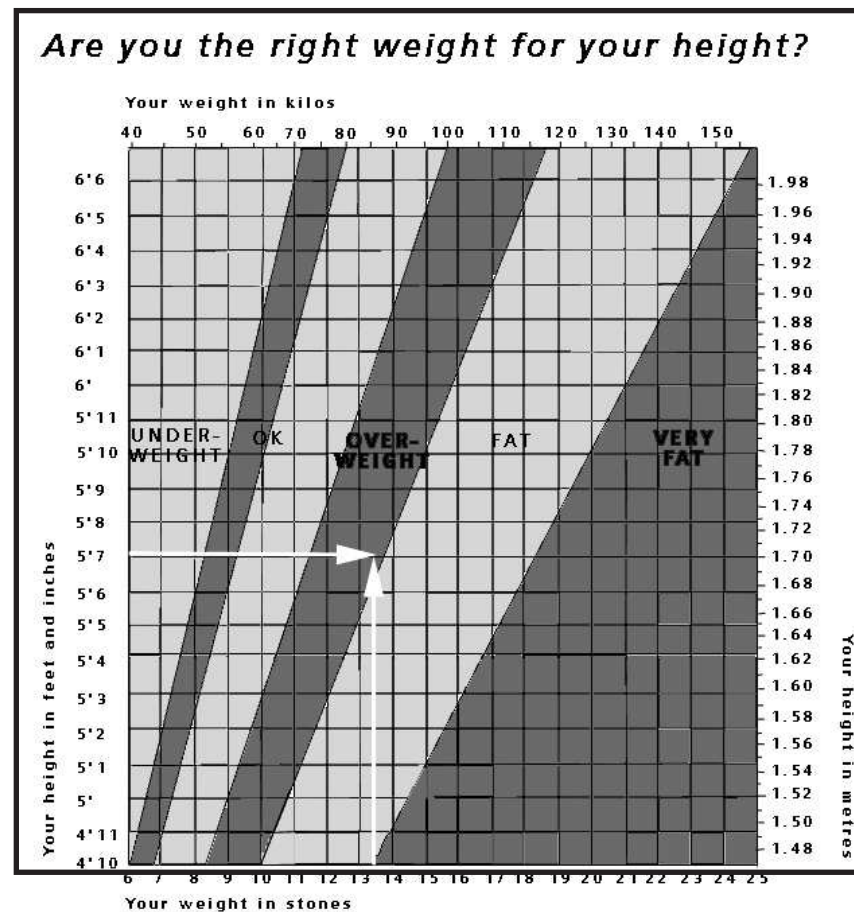
.....
.....
.....

Please refer to communication board 'Private health issues' if needed

My Health Action Plan - what I need to think about

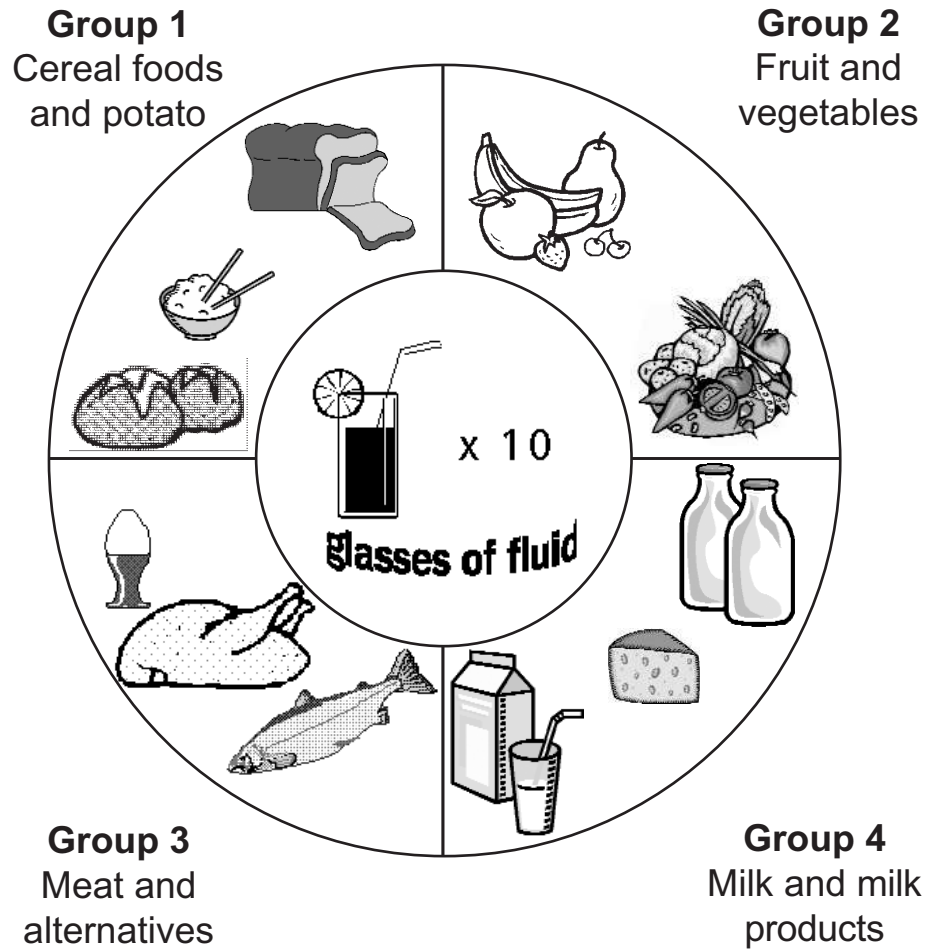


Check your weight



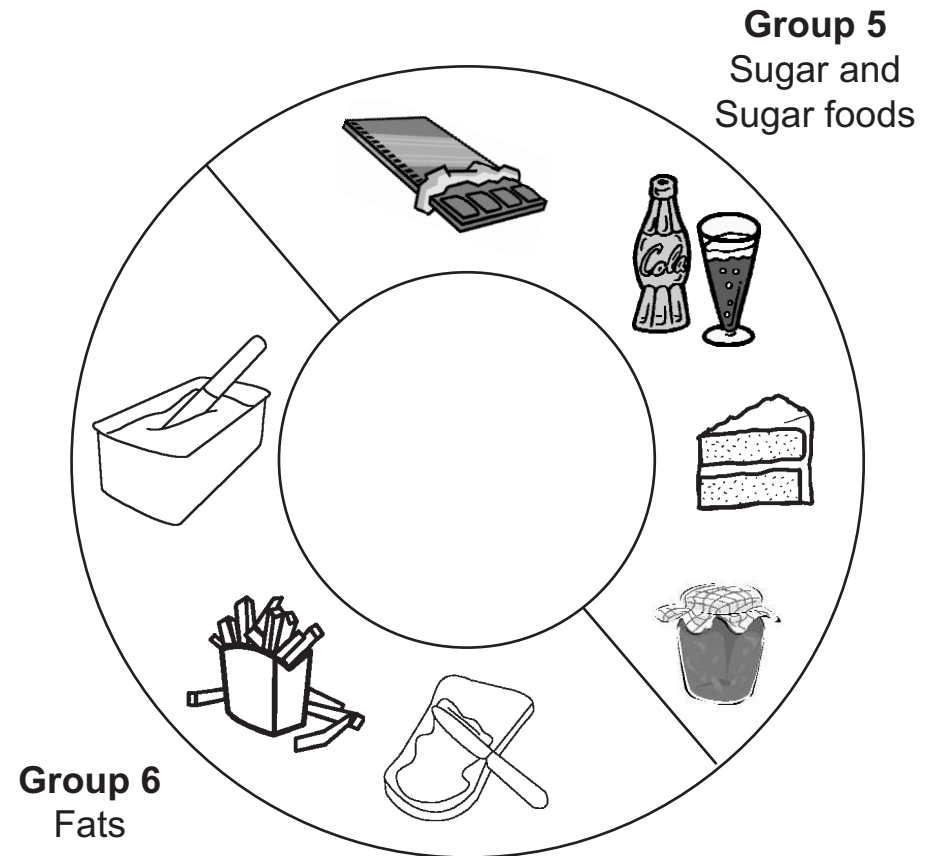
Good food guide

A combination of foods from each group will provide a good diet




















Foods to avoid

These foods are only OK in small amounts



I have an action plan for my:

	Health problem	Yes tick box	Staff name and date
	Mental health and behaviour	<input type="checkbox"/>	
	Epilepsy	<input type="checkbox"/>	
	Eating and drinking	<input type="checkbox"/>	
	Medication	<input type="checkbox"/>	
	Mobility	<input type="checkbox"/>	
	Stomach	<input type="checkbox"/>	
	Bladder and bowels	<input type="checkbox"/>	
	Heart and lungs	<input type="checkbox"/>	
	Diabetes	<input type="checkbox"/>	

	Health problem	Yes tick box	Staff name and date
	Asthma	<input type="checkbox"/>	
	Allergies	<input type="checkbox"/>	
	Teeth	<input type="checkbox"/>	
	Eyes	<input type="checkbox"/>	
	Ears	<input type="checkbox"/>	
	Sleep	<input type="checkbox"/>	
	Hand / foot care	<input type="checkbox"/>	
	Skin/ hair care	<input type="checkbox"/>	

Health Action plan record continued

Include plans for women's/men's private health e.g. breast, prostate, problems or long term conditions e.g cancer

Health problem	Yes tick box	Staff name and date
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	

Health Action plan record continued

Include plans for women's/men's private health e.g. breast, prostate, problems or long term conditions e.g cancer

Health problem	Yes tick box	Staff name and date
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	
Other - state	<input type="checkbox"/>	



My health action plan

Health issue	What the actions are <i>(Please print)</i>	By whom / when	Review date



My health action plan

Health issue	What the actions are <i>(Please print)</i>	By whom / when	Review date



Women's and men's health checks (breast check, cervical smear, prostate checks, testicular checks)

Type of check and date	Reason for attending	What happened Next appointment <i>(Please print)</i>



Women's and men's health checks (breast check, cervical smear, prostate checks, testicular checks)

Type of check and date	Reason for attending	What happened Next appointment <i>(Please print)</i>



My Annual Health Check and outcomes

Date/name of doctor or nurse	Outcomes Date of next annual health check <i>(Please print)</i>



My Annual Health Check and outcomes

Date/name of doctor or nurse	Outcomes Date of next annual health check <i>(Please print)</i>

Other GP and Practice Nurse appointments and outcomes

Date and time	Why did you visit your GP or nurse?	What happened Date of next appointment <i>(Please print)</i>

Other GP and Practice Nurse appointments and outcomes

Date and time	Why did you visit your GP or nurse?	What happened Date of next appointment <i>(Please print)</i>

This is my surgery



The doctors who work at the surgery are:

.....
.....
.....
.....
.....
.....

This is my surgery



The doctors who work at the surgery are:

.....
.....
.....
.....
.....
.....



Audiology appointments and outcomes

(Please print)

Date and time	Why did you visit your audiologist?	What happened Date of next appointment



Audiology appointments and outcomes

(Please print)

Date and time	Why did you visit your audiologist?	What happened Date of next appointment



Chiroprody appointments and outcomes

(Please print)

Date and staff name	Why did you visit your chiroprapist?	What happened Date of next appointment



Chiroprody appointments and outcomes

(Please print)

Date and staff name	Why did you visit your chiroprapist?	What happened Date of next appointment



Community clinical appointments & outcomes

(Nursing, OT, Psychology,
Psychiatry, Physiotherapy, SaLT)

Date and staff name	Reason for appointment	What happened Date of next appointment <i>(Please print)</i>



Community clinical appointments & outcomes

(Nursing, OT, Psychology,
Psychiatry, Physiotherapy, SaLT)

Date and staff name	Reason for appointment	What happened Date of next appointment <i>(Please print)</i>



Dentist appointments and outcomes

(Please print)

Date and time	Why did you visit your dentist?	What happened Date of next appointment



Dentist appointments and outcomes

(Please print)

Date and time	Why did you visit your dentist?	What happened Date of next appointment



Hospital appointments and outcomes (x ray, MRI scans, diabetes, epilepsy, cardiology, videofluoroscopy, A&E)

Date and time	Why did you visit the hospital and who did you see?	What happened Date of next appointment <i>(Please print)</i>



Hospital appointments and outcomes (x ray, MRI scans, diabetes, epilepsy, cardiology, videofluoroscopy, A&E)

Date and time	Why did you visit the hospital and who did you see?	What happened Date of next appointment <i>(Please print)</i>



Optician appointments and outcomes

(Please print)

Date and time	Why did you visit your optician?	What happened Date of next appointment



Optician appointments and outcomes

(Please print)

Date and time	Why did you visit your optician?	What happened Date of next appointment



Other appointments and outcomes (ie Sleep clinic, hand and foot care, skin and hair care)
(Please print)

Date and staff name	Why did you visit?	What happened Date of next appointment



Other appointments and outcomes (ie Sleep clinic, hand and foot care, skin and hair care)
(Please print)

Date and staff name	Why did you visit?	What happened Date of next appointment



Ageing issues

Completed by (relationship)

..... Date.....

(Please tick box)

I attend a memory clinic

A description of my problem(s) are:

.....
.....
.....
.....
.....

I am having help in the following areas:

.....
.....
.....
.....
.....
.....
.....
.....
.....

My medication helps me to:

.....
.....
.....
.....

Medication details are recorded in the 'Medication' section YES/NO

People involved in my care are:

.....
.....
.....
.....
.....
.....
.....

Any other information

.....
.....
.....
.....
.....
.....



Specialist care (End of life care)

Completed by (relationship)

..... Date.....

(Please tick box)

I am able to make a plan for my specialist care.

My health now

(Think about whilst you have been ill what has been happening to you)?

.....
.....
.....
.....
.....
.....
.....

What I want for my future care?

(Think about what's important for you)?

.....
.....
.....
.....
.....
.....
.....

How I want to be looked after *(think about help with feelings, pain, feeling sick, types of treatment)*

.....
.....
.....
.....
.....
.....
.....

Where I want to live

(Think about what's important for you? Staying where you are, being in a hospice, hospital, or being with family)

.....
.....
.....
.....
.....
.....
.....

