



# My Health Passport



**My name is**

If I have to go to hospital, this book needs to go with me. It gives hospital staff important information about me.



**Nursing and medical staff:**

This needs to hang on the end of my bed.

A copy should be put in my notes.



**This passport belongs to me. Please return it when I am discharged.**



**Nursing and medical staff:**

Please look at my passport before you do any interventions with me.

## This passport includes:



**Summary sheet about my needs ..... 2**

● Things you must know about me ..... 3

**Decision making ..... 6**

● Things that are important to me ..... 8

**How you know I am in pain ..... 10**

● Things that I like and do not like ..... 11

**Additional information ..... 12**

**Key contacts ..... 13**



**My communication needs** (the language I speak, do I use words, pictures, gestures or Makaton):



**How you will know I am in pain or uncomfortable:**



**My medication and allergies:**



**Eating, drinking and using the toilet** (any help I need, do I wear dentures, do I have swallowing problems, what is my diet, do I use continence aids, how I will let you know if I need help):



**Nursing and medical staff:**

- Please use the communication resources on the ward intranet.
- Please remember that mental capacity is decision-specific.
- Please remember to make reasonable adjustments. The use of **TEACH** may help:
  - **Time** – provide extra time or a second appointment; put me first on the list so I don't have to wait
  - **Environment** – think about using a side room, dimming the lights
  - **Attitude** – don't make assumptions and don't judge
  - **Communication** – think about using pictures to help explain things
  - **Help** – know when to ask family, carers or other professionals.

Date completed

Completed by



**My name:**

**I like to be known as:**

**My NHS number:**

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**My date of birth:**

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**My address:**

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**My phone number:**

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**How I communicate and the language I speak:**

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**Family, carer or other support contact:**

**Their name:**

**Their relationship to me (like mum, dad, home manager, support worker):**

**Their address:**

**Their phone number:**

**[More contacts are listed on page 14](#)**

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**My support needs and who gives me the most support:**

**The language my carer speaks:**



**My GP practice:**

Their address:

Their phone number:

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**Other services or professionals involved with me:**

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**My religion:**

**My religious or spiritual needs:**

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**My ethnicity:**

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**My allergies:**

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**My medical interventions (like how to take my blood, give injections, take my blood pressure):**

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**My heart conditions:**

**My breathing problems:**

Date completed

Completed by



**My risk of choking or having problems swallowing:**



**My current medication:**



**My medical history and treatment plan:**



**What to do if I am anxious (worried):**

Date completed

Completed by



## Nursing and medical staff:

Note that the main outcomes from LeDeR (leading causes of death) are: constipation, pneumonia, acid reflux, swallowing issues, epilepsy, recurrent falls, respiratory failure, cardiovascular.



If you are aged 18 or over and can make your own decisions, you can use a legal document called a **Lasting Power of Attorney** to name someone to make decisions for you if you cannot make your own decisions in the future.

I have a Lasting Power of Attorney:

Yes      No

I have a Health and Welfare Power of Attorney:

Yes      No

I have a Property and Financial Power of Attorney:

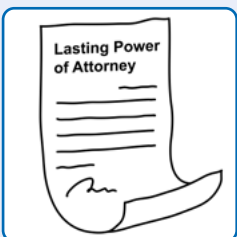
Yes      No



As part of your ongoing health and care support, you might be eligible for **funding** (financial help) to meet some of your health and care needs. This could be from your local council or, in some circumstances, from the NHS.

I am funded by:

- Section 117
- Continuing healthcare (CHC)
- Local authority (council)
- Self-funded
- Join-funded CHC



If you are at risk of harm to yourself or to others and need urgent mental health treatment, but it is felt you are not able to make the right decisions about your treatment, you may be detained (sectioned) under the **Mental Health Act**. This law means you may be treated without your agreement, but it will only be done to make sure you get the treatment you need..

I am under the Mental Health Act:

Yes      No



If you are aged 16 or over and have been assessed as not being able to make your own decisions, The Mental Capacity Act can protect you and make sure any decisions made about you are in your best interests. Local **Mental Capacity Act** policies and the Mental Capacity Act Code of Practice must be followed.

If I am assessed as not being able to consent to my treatment, these people must be involved in any decisions about me:

**Contact 1**

Their name:

Their relationship to me:

Their contact details:

**Contact 2**

Their name:

Their relationship to me:

Their contact details:



**How to communicate with me** (do I use words, pictures, gestures or Makaton):



**How I take medication** (do I take whole tablets, crushed tablets, injections or syrup):



**How I move around** (my posture in bed, do I use walking aids):



**Personal care** (any help I need with dressing or washing):



**Seeing and hearing** (any help I need, do I wear hearing aids or glasses):

Date completed

Completed by





**Eating** (any help I need, how I will let you know if I need help, do I wear dentures):



**Drinking** (any help I need, how I will let you know if I need help, how much do I drink, do I need thickened fluids):



**How I keep safe** (do I need bed rails, any help I need with challenging behaviour):



**Using the toilet** (any help I need, how I will let you know if I need help, do I use continence aids):

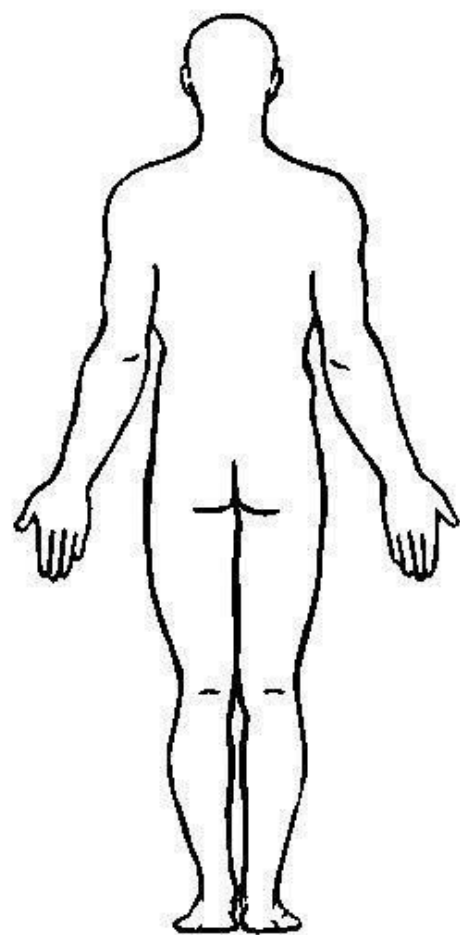
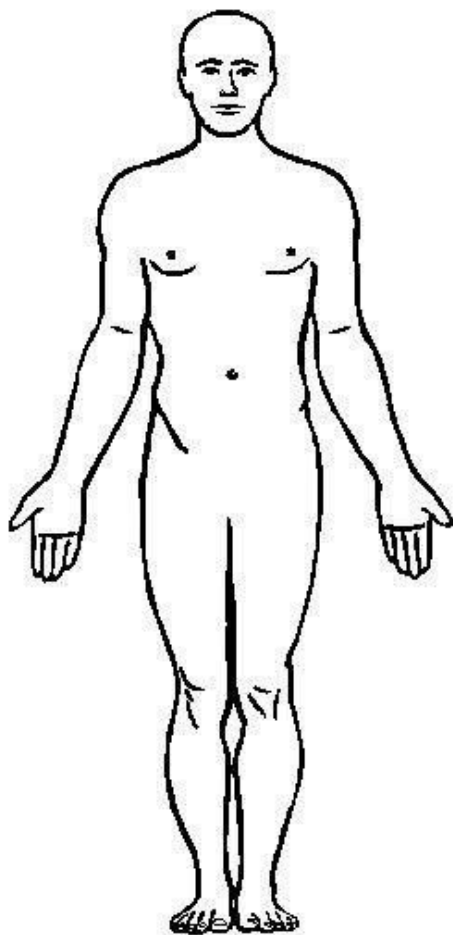
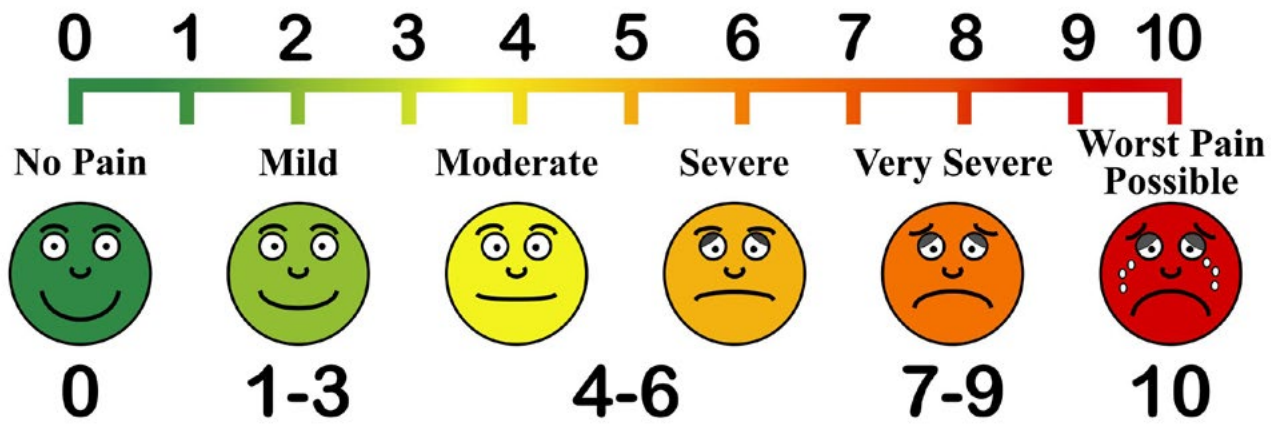


**Sleeping** (my sleep pattern and routine):

Date completed

Completed by

# PAIN ASSESSMENT TOOL



Date completed

Completed by



**Things that I like** (what makes me happy and what do I like to do, like watching TV, reading, music, routines).

Please do this:



**Things that I do not like** (what makes me unhappy and what do I not like to do, like shouting, being touched, certain foods).

Please do not do this:

## The five principles of the Mental Capacity Act:



Everyone has the right to make their own decisions and must be assumed to have mental capacity unless proven otherwise.



Everyone must be supported as much as possible to make their own decisions before anyone says that they are not able to.



Everyone has the right to make what others might think are unwise decisions.



Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

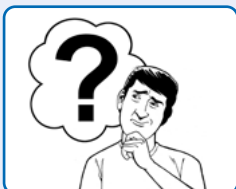


Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms.



### **Nursing and medical staff:**

- Please refer to my summary care records for my most recent medications.
- Please always follow the Mental Capacity Act 2019 principles for all aspects of decision-making.



Please contact your local community learning disability team if you have any questions about the passport.

**Community Learning Disability Health Team**

Address: 41 Broom Street, Hanley, Stoke-on-Trent ST1 2EW

Phone: 0300 123 1152 or 0300 123 1152



#### Adult learning disability social care contacts:

- **First contact**

Phone: 01785 278444

Email: [AdultFirstContactReferrals@staffordshire.gov.uk](mailto:AdultFirstContactReferrals@staffordshire.gov.uk)

- **Adult Learning Disability Team North**

Phone: 01782 485020

Email: [ALDTnorthduty@staffordshire.gov.uk](mailto:ALDTnorthduty@staffordshire.gov.uk)

- **Adult Learning Disability Team South**

Phone: 01543 334888

Email: [ALDTsouthduty@staffordshire.gov.uk](mailto:ALDTsouthduty@staffordshire.gov.uk)

- **Young Adults Learning Disability Team**

Phone: 01785 278472

Email: [ALDTyoungadultsduty@staffordshire.gov.uk](mailto:ALDTyoungadultsduty@staffordshire.gov.uk)



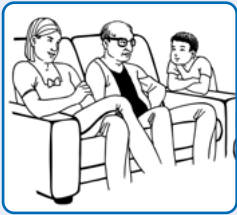
#### Local safeguarding teams:

- **Stoke-on-Trent City Council**

Phone: 0800 561 0015

- **Staffordshire County Council**

Phone: 0845 604 2719



**Any other family, carer or other support contacts:**

**Contact 1**

Their name:

Their relationship to me (like mum, dad, home manager, support worker):

Their contact details:

Their phone number:

**Contact 2**

Their name:

Their relationship to me (like mum, dad, home manager, support worker):

Their contact details:

Their phone number:



**Useful websites:**

- [www.easyhealth.org.uk](http://www.easyhealth.org.uk)
- [www.intellectualdisability.info](http://www.intellectualdisability.info)
- [www.mencap.org.uk/gettingitright](http://www.mencap.org.uk/gettingitright)

This Health Passport was developed by the Staffordshire and Stoke-on-Trent LeDeR Programme and the Health Facilitation Team - Community Learning Disability Health Team and based on original work by Gloucester Partnership NHS Trust

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