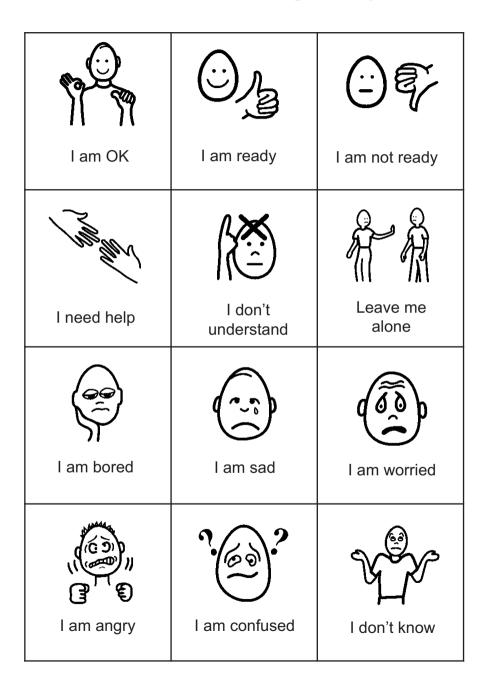
I have something to say



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.

Contract of the second			
I have a hospital	passport. (Ple	ease 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.

(Information from NHS Inform, Scotland)

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My support plan

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



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:
•
•

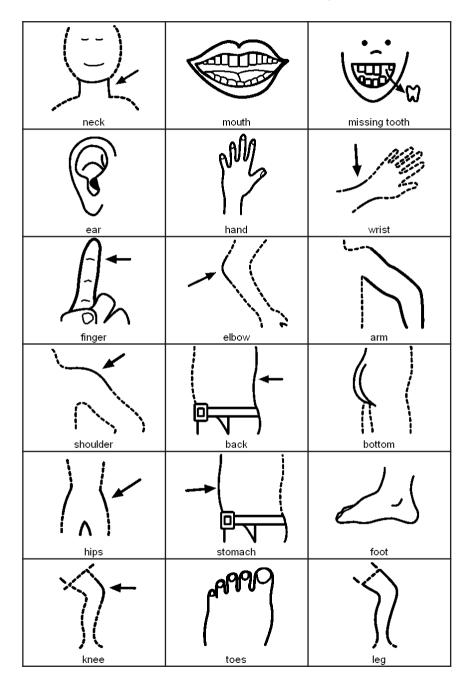
Other important people/organisations to contact

Name of person and organisation	Address and telephone number

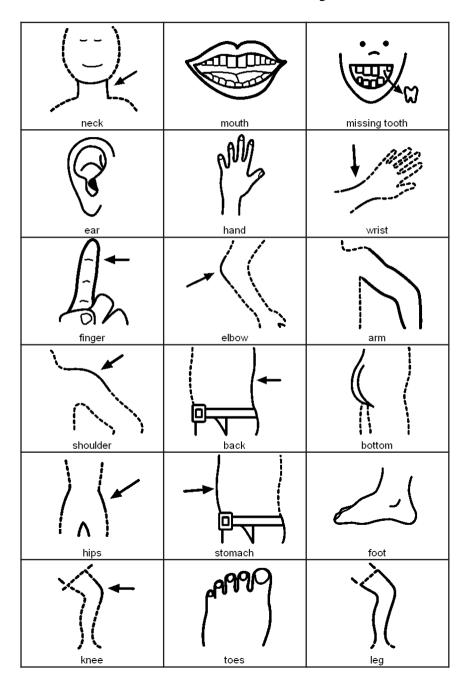
Other important people/organisations to contact

Name of person and organisation	Address and telephone number

Parts of the body



Parts of the body





People who are important to me

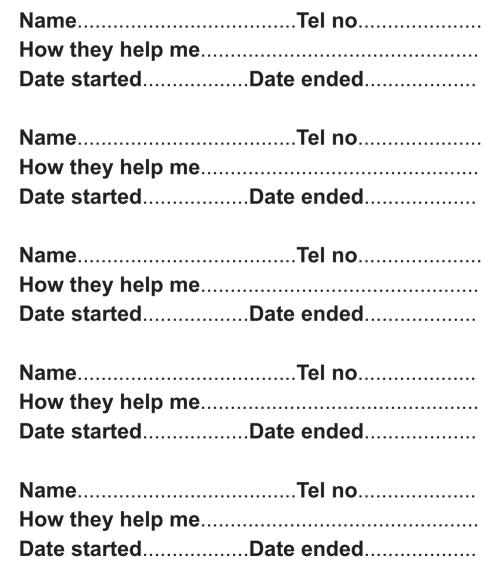


People who are important to me

Name	Tel no
How they help me	
Date started	Date ended
Name	Tel no
How they help me	
	Date ended
Name	Tel no
How they help me	
Date started	Date ended
Name	Tel no
Date started	Date ended
Name	Tel no
How they help me	
Date started	Date ended



People who are important to me



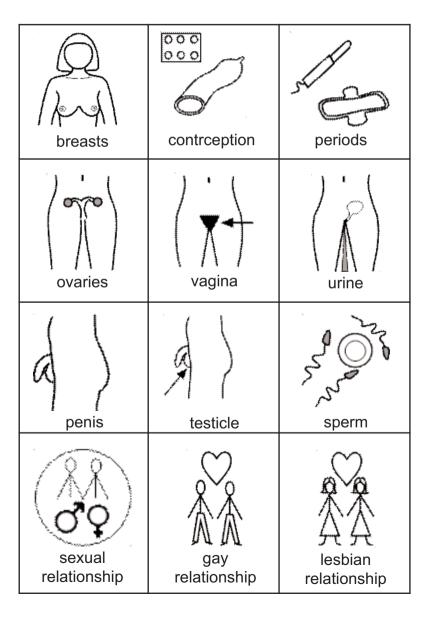


People who are important to me

Name	Tel no
Date started	Date ended
Name	Tel no
How they help me	
	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
	Date ended

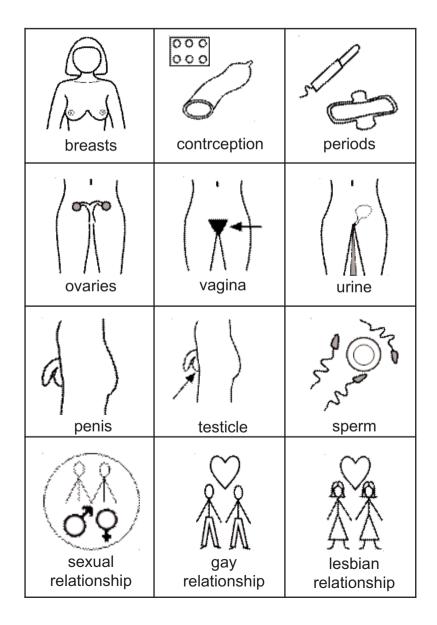
Private health issues

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



Date	What has changed	Name / job

Date	What has changed	Name / job



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

Date	What has changed	Name / job

Date	What has changed	Name / job

BI	adder ar	nd bowels
Co	mpleted by	(relationship)
		Date
(Please tick box)		
I need help us	ing the toile	t. I need help with:
<u> </u>		
I have had a c	ontinence a	ssessment:
—		
require:		
Items	Date	Details
pads		
sheats		
commode		
urine bottle		
reminders		
toiletting plan		
medicine		
other		
other		
other		

Date	What has changed	Name / job

-		Ears
P.	A STATE OF THE PARTY OF THE PAR	Completed by (relationship)
A-		Date
(Plea	se tick box)	
	I do not ha	ve problems with my hearing.
	I do have p	roblems with my hearing.
The	details of my	problem(s) are:
	I (or others) have been concerned about my
	hearing be	cause
	I have had	my hearing tested.
	It would be	easier to have my ears tested if:
		aring aid. It helps/does not help my
	hearing (de	elete as appropriate).

Date	What has changed	Name / job

I have problems I need a modifie Details (pureed, i	eating and o	y (relation		••••
I need my fluids Details: I need a special	diet for med	lical or		
personal reasor	is:			
Diabetic	Gluten free		Low fat	
High fibre	Vegetarian		Soft foods	
Warning signs If I gag, cough, che food and drink in n			•	

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.

Date	
can feed myself need the following special equipment and/or promp	ots

I need the following special equipment and/or prompts

I need the following special equipment and/or prompts

I can have a drink on my own

I need help with eating and drinking

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

	Epilepsy Completed by (relationship)Date
This is what hap	pens:
	g to have a fit when:
This is the help I Before:	need:
During:	

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.

KHOR	Eyes
	Completed by (relationship)
	Date
(Please tick box)	
I do not hav	ve problems with my sight.
☐ I do have p	roblems with my sight.
The details of my	problem(s) are:
Please include co	onditions like glaucoma, cataract.
Π	
	ered blind or partially blind
	ses or contact lenses
☐ I have my e	eyes checked regularly
The second of	la alla mana sellata assa alla di di
i ne optician can	help me with eye checks by:

Eye test results

Optometrist/Optician name					Pr	actice	nan	ne ar	nd ad	dress			
Date Signed													
	Unaided	Sph	Cyl	Axis	Prism	VA	\neg	Unaided	Sph	Cyl	Axis	Prism	VA
	Vision	Opii	Oy.	AXIS	1 113111	" ^		Vision	Opii	oy.	AXIS	1 113111	
Dist													
Near													
Acuity	y method	or des	scriptio	on of fu	ınctiona	ıl vi	sior	1					
		R	ight							Left			
Glass	es nee	ded: Y	es/No)									
Dista	nce (TV	and v	walkin	g aro	und): Y	es/	Νo	To b	e wor	n all t	he tin	ne: Yes	/No
Near	(eating	and c	lose t	asks):	Yes/N	lo		Bifo	cal or	Multif	ocal:	Yes/No)
Comments:													
Other problems with eyes (lazy eye, squint, cataract, nystagmus (wobbly eye), keratoconus, glaucoma:													
Advice on eyes and vision													

6		Hand and foot care				
		Completed by (relationship)				
		Date				
(Plea	se tick box)					
\square	I need help	with my fingernail care.				
Щ	I need help	with my toenail care.				
Щ	I have pain	or discomfort in my feet.				
	I wear mad	e to measure shoes				
Deta	ils of the ak	oove:				
Ш	I have special hand or foot requirements					
	(e.g. circula	ation, oedema). Please give details:				
·····	Other detai	lo.				
	Other detail	IS.				

Date	What has changed	Name / job
	<u> </u>	

	ANT.	1
7		

Men's health and well being

	Completed by (relationship)
N. Sheet	Date
Please tick box)
\neg	
I have bee	n shown how to check for lumps in my
testicles or	r around my penis
I have bee	n given advice about men's health
(e.g. prosti	rate/testicular cancer)
	n given information/advice about safe
sex and co	ontraception
The help I need	to attend appointments involving
ntimate persona	al examination is:



Иy	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 prob	lems with my mental health /		
behaviour t	that worry me and other people.		
These problems	are:		
My main worries	and anxieties are:		
The risks that the	ese 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)

What helps me the most is:			
I have guidelines I have a risk assessment I have a CPA Other details:			
Medication details are recorded in the 'Medication' section YES/NO			

Date	What has changed	Name / job

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19,000

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: During:

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.

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A NO	
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Information about my nhysical disability

the state of the s		Co	ompleted by (relationship)Date
I ha	ive pr	oblems wit	h the following:
		my arms & hands	
		my legs & feet	
		my spine	
		my face	
		my neck	
		other	
The	ese pr	oblems aff	ect me by:



Mobility and equipment

Completed by (relationship)Date.....

l	require the regular use of:			

equip	oment	
	wheelchair	
	specialist seating	
	hoist	
	standing frame	
	foot straps	
	wrist straps	
	wedges	
	helmet	
	splints	
	oxygen	
	suction	
	tube feeding	
	cutlery	
	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:
\neg	
	I would like to have a boy/girl friend.
	Ways to meet someone:

Date	What has changed	Name / job

(Please tick box) I have proble	Skin and hair care Completed by (relationship) Date ems with my skin. ems with my hair.
problem	details
acne	
eczema	
psoriasis	
soreness	
pressure areas	
itching	
dry patches	
hair loss	
dandruff	
head lice	
Other details:	

Date	What has changed	Name / job

	Teeth
	Completed by (relationship)
	Date
(Please tick box)	
I go for a d	ental check every six months.
I wear dent	ures.
☐ I have prob	elems with my teeth and gums.
A description of r	my problem(s) are:
☐ I (or others	have been concerned about my teeth
and gums.	
The concerns are	9:

Date	What has changed	Name / job

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



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



1	
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١	

Women's health and well heina

(Please tick box)	Completed by (relationship)
I have bee lumps, and There is a Please give fami	a well women clinic n shown how to check my breast for d changes in shape. history of breast cancer in my family. ly details
\neg	olems with my periods. They are:
I have bee	n given information/advice on safe sex, ion and women's health pregnancy/terminations

5
,

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.

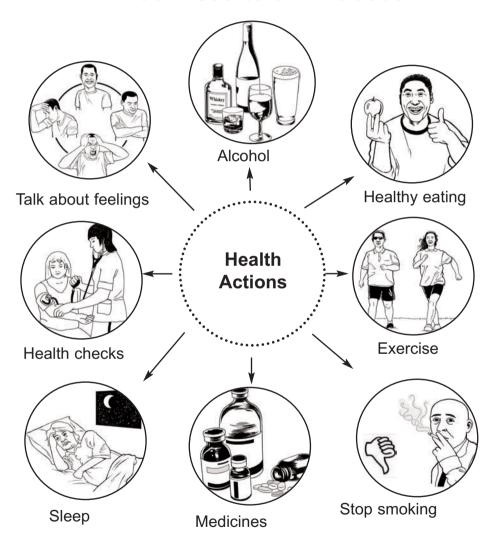
Things	that ha	ve happ	ened to	o me:		

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

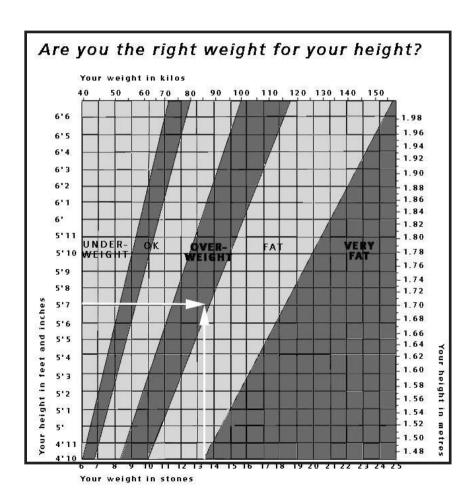
Date	What has changed	Name / job

Date	What has changed	Name / job

My Health Action Plan - what I need to think about

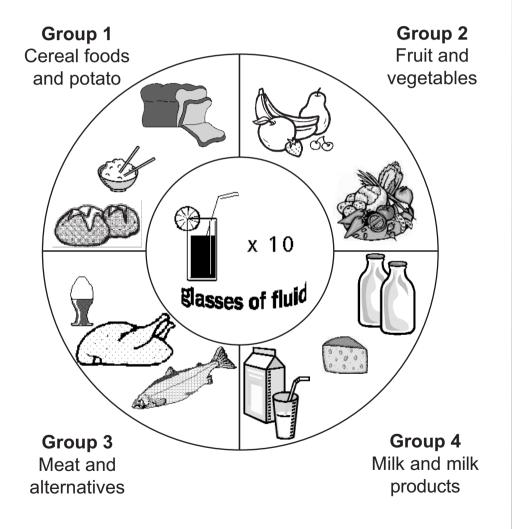


Check your weight



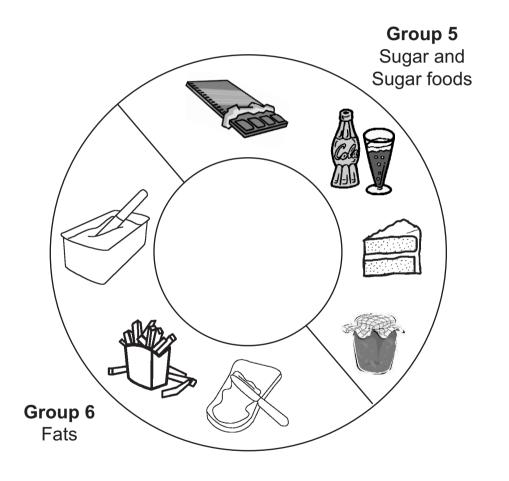
Good food guide

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



Foods to avoid

These foods are only OK in small amounts





My Health Action Plan -

Good things a	bout my health
Jood Illingo a	boat my moantin
I need help with	th
_	
-	

I need help with:

I have an action plan for my:

	Health problem	Yes tick box	Staff name and date
	Mental health and behaviour		
	Epilepsy		
	Eating and drinking		
	Medication		
	Mobility		
	Stomach		
	Bladder and bowels		
G	Heart and lungs		
Jam	Diabetes		

	Health problem	Yes tick box	Staff name and date
W. T. W.	Asthma		una dato
	Allergies		
	Teeth		
	Eyes		
	Ears		
	Sleep		
	Hand / foot care		
	Skin/ hair care		

Health Action plan record continued

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

Health problem	Staff name and date
Other - state	

Health Action plan record continued

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

Health problem	Staff name and date
Other - state	



My health action plan

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



My health action plan

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



Healthy Living

Completed by (relationship)Date

(Please giv	ve details)
	I exercise
TYBER OF THE PERSON OF THE PER	I drink alcohol
	I smoke
Lots of	I have been given advice on healthy
Into	lifestyles. YES/NO Any other details:

Other health information about me:			

Date	What has changed	Name / job

Date	What has changed	Name / job



Blood pressure and pulse rate readings

Date/Name	Blood pressure	Pulse rate



Blood pressure and pulse rate readings

Date/Name	Blood pressure	Pulse rate

Blood test record



Date/Name	Reason for blood test	Any action

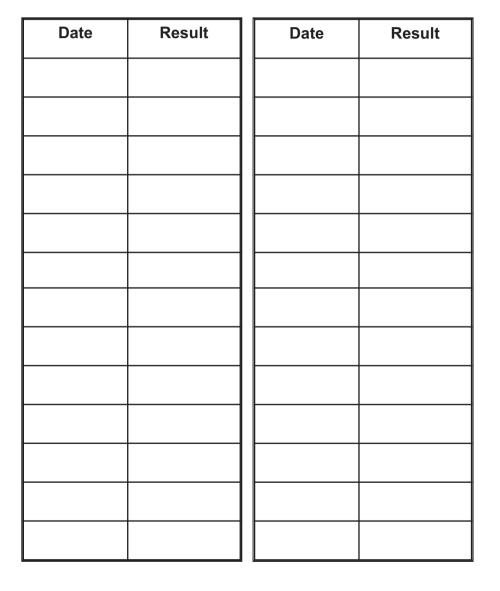
Blood test record



Date/Name	Reason for blood test	Any action



Cholesterol checks





Cholesterol checks

Date	Result	Date	Result



Early warning signs monitoring

Date	Time	Breaths per min	Pulse per min	Temp	Other



Early warning signs monitoring

Date	Time	Breaths per min	Pulse per min	Temp	Other



Family history

Details of my family's medical history Completed by (relationship)

 D	ate

Type of problem	Who has it?	Brief description
Heart problem		
Blood pressure		
Diabetes		
Sickle cell		
Asthma		
Stroke		
Cancer		
Osteoporosis		
Mental health		
Alzheimers		
Learning disability		
Epilepsy		
Other		
Other		
Other		

Other health history/any other relevant information



Height and weight records

Date	Height	Weight	ВМІ



Height and weight records

Date	Height	Weight	ВМІ



Immunisation record

Completed by (relationship)
Date

I have been immunised against the following:

Immunisation	Date	Details	Name/job
Measles			
Mumps			
Rubella			
Diptheria			
Whooping cough			
ТВ			
Polio			
Tetanus			
Hepatitis B			
Meningitis C			
Flu			
Other			

Best way to prepare me for an injection		

Update page (include flu jabs)

Immunisation	Date	Details	Name and job



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

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



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

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

Date	What has changed	Name / job

Date	What has changed	Name / job



My Annual Health Check and outcomes

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



My Annual Health Check and outcomes

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

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 (Please print)

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 (Please print)

This is my surgery	This is my surgery
The doctors who work at the	The doctors who work at the
surgery are:	surgery are:

Date	What has changed	Name / job

Date	What has changed	Name / job



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



Chiropody appointments and outcomes

(Please print)

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



Chiropody appointments and outcomes

(Please print)

Date and staff name	Why did you visit your chiropodist?	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 (Please print)



Community clinical appointments & outcomes

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

Date and staff name	Reason for appointment	What happened Date of next appointment (Please print)



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 (Please print)



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 (Please print)



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)

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



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)

Why did you visit?	What happened Date of next appointment
	visit?

Date	What has changed	Name / job

Date	What has changed	Name / job

	Ageing issues
	Completed by (relationship)
	Date
(Please tick box)	
I attend a n	nemory clinic
	•
A description of r	my problem(s) are:
•	
I am having help	in the following areas:
r am naving neip	_

My medication helps me to:
Medication details are recorded in the 'Medication' section YES/NO
People involved in my care are:
Any other information

0	Specialist care (End of life care)
	Completed by (relationship)
	Date
(Please tick box)	
I am able to	o 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 n	ny future care?
(Think about what's imp	
	· · · · · · · · · · · · · · · · · · ·

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)



My final wishes

(End of life care)

Completed by (relationship)

..... Date.....

My plan needs to include	My	plan	needs	to	include	;
--------------------------	----	------	-------	----	---------	----------

- where I want to be when I die.
- who I want with me.
- how I want to be supported.

what I want to happen at my funeral.

Continued

Date	What has changed	Name / job

Date	What has changed	Name / job