Keeping Healthy
my Health Passport

NHS Stockport Clinical Commissioning Group

- This passport is designed for people with Learning Disabilities to complete with support from their families, friends or carers
- Take this with you to healthcare appointments, to let staff know your needs
- Ask hospital staff to keep it at the end of your bed with medical notes
- Remember to take this home after your appointments.

Traffic Light Assessment:

This information in this passport is rated as follows:

Red	Things you **must** know about me
Amber	Things that are **really important** to me and my care
Green	Things I would **like** to happen, my **likes and dislikes**

MY NAME:		**NHS Number:**	

useful contacts

Role	Name	Phone
Emergency Contact		
Next of Kin		
My GP		
Community Learning Disability Team		0161 218 1220
Hospital Liaison Nurse		
Physiotherapist		
Occupational Therapist		
Social worker		
My Local Pharmacy		
My Dentist		
My Optician		
My Audiologist		
Other		

red alert – things you must know about me

Address:

Date of Birth:

Religious requests:

Communication How I communicate and understand:

Personal Care Washing, dressing etc:

Eating / Drinking Help with feeding, cutting food, choking risk, temperature, equipment:

Staff support What support my usual carers will provide while I am in hospital:

Taking medication Crushed tablets, syrup, PEG etc:

Current Medication:

Known Conditions: (Downs Syndrome, Autistic Spectrum Disorder, Acquired Brain Injury, Dementia..)

Allergies:

Medical interventions (how to support me if you need to give me my medication, take my blood, give injections etc):

Behaviour (Is a risk assessment required for behaviours which may put me or those around me at risk? E.g. reaction to loud noises):

Consent:

Level of learning disability:……

☐ I want an advocate to help me take decisions

PLEASE REMEMBER THAT I MAY HAVE CAPACITY TO CONSENT TO SOME THINGS BUT NOT OTHERS.

Amber alert – things that are **really** important to me

Pain / Distress How you know I am in pain or distress:

Keeping safe Bed rails, pressure care etc:

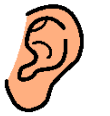
Comfort How you can comfort me if I'm upset:

Seeing Problems with sight:

Glasses

☐ I wear glasses all the time ☐ I wear glasses for reading

Where I keep them: ……..



Hearing Problems with hearing:

Hearing aids

☐ I have a hearing aid for my **LEFT** ear ☐ I have a hearing aid for my **RIGHT** ear

Where I keep them: ……..

Sleeping Sleep patterns, positioning:

Moving around Positioning, walking aids, hoists etc:

Going to the toilet Continence aids, support needed:

Care Plans

☐ I follow a care plan for ……..

You can get a copy from: NAME:……PHONE:……

Green – things I would like to happen

Think about –what makes you happy, what upsets you, things you like to do i.e. watching TV, reading, music. How you want people to talk to you. Food likes, dislikes, physical touch, specific needs, routines, things that help you feel safe.

✓ **Things I like** Please do this: 	✗ **Things I don't like** Please don't do this: 

Reasonable adjustments required for my care:

Is there anything else you would like us to know?

☐ I have a health action plan. You can get a copy from NAME: …….. PHONE:……..

Form completed by: Date last updated: