

A picture of Me

**My**

**Health Passport**

**My name is**

**I like to be known as**

**My address is**

**I live (✓)**

**The person who knows me best is**

With my family

With Staff

By my self

Phone No

This information belongs to me.

Please share my information with other health professionals involved in my care.

**Please return my passport to me when I leave hospital**

This passport will help hospital staff make my stay better.

Staff call this Reasonable Adjustments

**RA**

**Consent to Treatment:** Please follow the Mental Capacity Act guidelines to obtain consent for any treatment

**DNA-CPR:** I have / do not have an advance decision about resuscitation.

Nursing and medical staff, please look at my information before any interventions take place.

Things you **must** know about me **immediately**

Things that are really important **FOR ME**

Things that are really important **TO ME**

Nursing and medical staff, please look at my information before any interventions take place.

Things you **must** know about me

Things that are **really** are important

What you **need** to know about me

**Things you must know about me**

Date Completed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with help from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My GP is Dr**……………………………………**Phone no**……………………

**I have these medical issues: ✓ DoB**…………………..…

**Diabetes Respiratory (breathing problems)**

**Cardiac (heart problems) Epilepsy**

**Dysphagia (eating & drinking problems) Other conditions:**

**I have these allergies:**

**RA**

**Communication -** How well I use and understand speech

This is how I say yes and no

**Pain-**How I show I am in pain and how to support me

**RA**

It is important you read my care plan for more detailed information

**Swallowing problems**–

**RA**

Do I need it to be liquid / crushed?

**Medication:-**How I take my medication and at what time

**RA**

What will help me to wait?

**Waiting during appointments and procedures:**

**-**

**RA**

**Things you must know about me**

e.g. Hoist, slings, bed bumpers, postural care equipment

**Posture and positioning –**The position I need to be in bed / wheelchair

**RA**

**Sight and Hearing-** any problems I have and any aids I use

**RA**

Do I need a risk assessment?

**Behaviour: –**Things I do that other people / staff might find difficult to manage

**RA**

Things that are really important **FOR ME**

**My sleep pattern:-**My routine going to bed / sleep

**RA**

**Moving around:-**Walking aids, wheelchair, hoist & slings

**RA**

**How I use the toilet:-**Continence aids I use, going to the toilet

**RA**

**Eating and drinking:-**Do I need help with eating, choosing a menu,

special diet or eating plan?

**RA**

**Personal Care:-**Dressing, washing, cleaning my teeth etc.

**RA**

**Things I dislike:-**

**Things I like:-**

**Information important to me:-** Family, friends, professionals

**Things that will make my stay WORSE:-**

**Things that will make my stay BETTER:-**

**Things that are important TO ME**

**These are the things that are really important to me and knowing about them will help you to make my stay in hospital better.**

**Please look at my likes and dislikes and remember them when planning my care.**

**Chester Social Services / Safeguarding Referrals**

**Gateway Team: - T:- 0300 123 7034**

**(Mon – Thurs 08.30hrs – 17.00hrs)**

**(Friday 08.30 – 16.30)**

**Social Services Emergency Duty Team T: - 01244 977277**

**Eastway Learning Disability Team: -**

**Countess of Chester Health Park**

**Liverpool Road**

**Chester**

**CH2 1BQ**

**Community Team – ask for Health Facilitators or Duty worker:- T: 01244 397222**

**Countess of Chester Hospital:- T: 01244 365000**

**PALS :- T: 0800 195 1241 and select option 2 or**

**(Patient advice and Liaison services) T: 01244 366066**

**Email PALS: E:** [**cochpals@nhs.net**](mailto:cochpals@nhs.net) **or**

**Write to**

**PALS Manager**

**Countess of Chester Hospital Foundation Trust,**

**Liverpool Road,**

**Chester CH2 1UL**

**Safeguarding and Complex Care Team:- T: 01244 364021 / 363608**

**For more information see** [**www.cwp.nhs.uk**](http://www.cwp.nhs.uk)

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**Contact details and useful information**

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**Community Team:- T: 01244 397222**

**Specialist Health Facilitator**

**Karen Brogan and Sue Booth**

**Hospital Discharge Information Plan**

**Name:……………………………. DOB:……………………………...**

**Date of admission:……………. Date of discharge:……………...**

**Ward/Department:………………………..**

**Consultant Name:………………………..**

**Present at Discharge Meeting:………………………………………………………………..**

**…………………………………………………………………………**

**…………………………………………………………………………**

**Apologies:………………………………………………………………………………………...**

**Why was the person admitted?.......................................................................................**

**What was the treatment?..................................................................................................**

**What is the diagnosis?.....................................................................................................**

**Who has seen them, i.e.** Speech and Language Therapist, Dietician etc.

………………………………………………………………………….

………………………………………………………………………….

………………………………………………………………………….

**Is there any equipment needed? Who is providing it?**

(walking frame, raised toilet seat, nebuliser, PEG feed, assistive technology)

……………………………………………………………….

……………………………………………………………….

……………………………………………………………….

**Hospital Discharge Information Plan**

**List of medication including changes/additions (Inc. liquid feed)**

Do carers understand what these are for/ how to administer / side effects?

**Any Follow-up appointments / out patients / district nurse referral?**

**Any other referrals required/additional funding required?**

Physiotherapy, swallowing assessment, Dietician, Community Learning Disability Nurse,

care management, Continuing Health Care

Referral to:…………………………………….Named person responsible……………………..

**Any infections/ pressure areas**

MRSA, C Difficile, other infections?

Who is managing these / have carers seen relevant policies/ need training / resources?

Any symptoms that need to be monitored:

**Please outline any action plan agreed/ any other issues :**

**Please remember to involve patient, parents and carers in discharge planning.**

**Signed: Date:**