This Health Information Passport has been adapted and redeveloped by Mersey & West Lancashire Teaching Hospitals Learning Disability Specialist Nurse 2023. It is based on original work by Gloucestershire Foundation Trust. Widget Symbols © copyright Widget Software 2009

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Health Passport

Nursing and Medical Staff please look at "My Health Passport "before you help me.

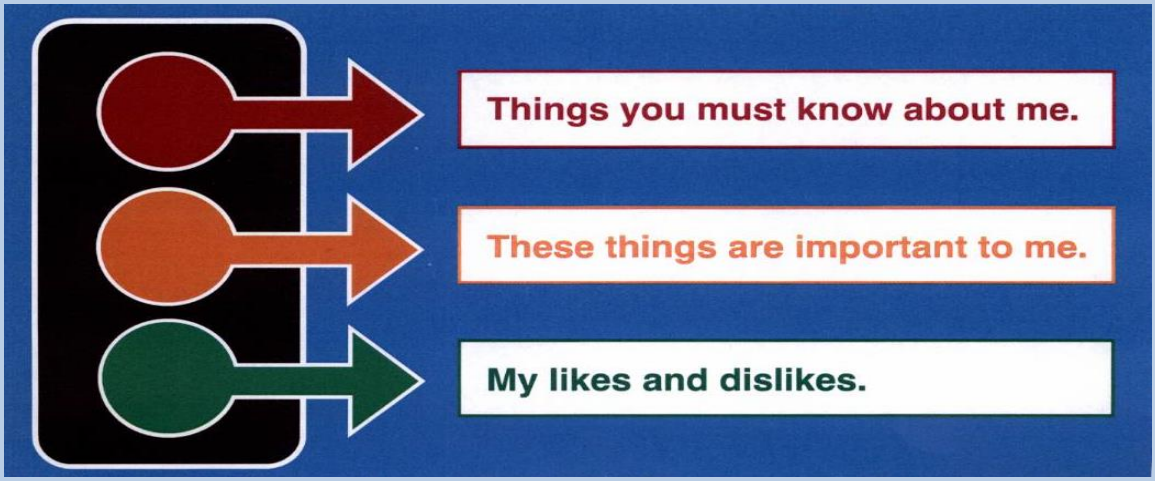
Reasonable Adjustments, please allow one person that, knows me well to accompany me within the Hospital (This Passport can be translated into different languages)

My name is: Click or tap here to enter text.

I like to be known as: Click or tap here to enter text.
DOB: Click or tap here to enter text.
Hospital No: Click or tap here to enter text.

Place your Photograph here

Completed by: Click or tap here to enter text.
Date: Click or tap to enter a date.



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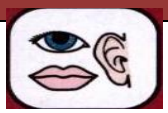
Department: Safeguarding
Document Number: MWL2157
Version: 001
Review Date: 30 / 04 / 2027

Name:
NHS:
DOB:

Things you must know about me…

	**How I communicate / what language I speak / how to communicate with me:** Click or tap here to enter text.		
	**My Address:** Click or tap here to enter text. **Post Code:** Click or tap here to enter text.		
	**My Contact Number:** Click or tap here to enter text.		
	**Who I live with:** **Family** ☐ **Co-tenants** ☐ **Supported Living** ☐ **Independent** ☐		
	**My next of kin:** Click or tap here to enter text. **Relationship (e.g. Mum, Dad, Friend)** Click or tap here to enter text. **Their Address:** Click or tap here to enter text. **Contact No:** Click or tap here to enter text.		
	My GP's Name Click or tap here to enter text. **Contact Number:** Click or tap here to enter text. **Their Address:** Click or tap here to enter text.		
	**Other Services / Professionals involved with me:** Click or tap here to enter text. **Name:** Click or tap here to enter text. **What is their role:** Click or tap here to enter text. **Contact Details** Click or tap here to enter text.		
	**Allergy Alert:** Click or tap here to enter text.		
	Any Phobias: Click or tap here to enter text.		
 	**My Height:** Click or tap here to enter text. **Date:** Click or tap to enter a date.	**My Weight:** Click or tap here to enter text. **Date:** Click or tap to enter a date.	**My BMI:** Click or tap here to enter text. **Date:** Click or tap to enter a date.
	**My Religion:** Click or tap here to enter text.	**My Ethnicity:** Click or tap here to enter text.	**My Religious needs:** Click or tap here to enter text.

Name:
NHS:
DOB:

Reasonable Adjustments
Things you must know about me to support me safely…

	**What reasonable adjustments need to be put in place to support me**
	**Medical Interventions: How to support me: e.g. blood pressure, taking bloods** Click or tap here to enter text.
	**Health Conditions e.g. heart disease, diabetes, asthma, cancer, mental health (depression, anxiety, psychosis), gastro-intestinal problems. How this presents itself and how to support me.** Click or tap here to enter text. (Consent: Lead Professional is responsible to consider Mental Capacity Act if the person consent to treatment Click or tap here to enter text.
	**My current medication: The dosage (how much) and tell us the form that it comes in e.g. tablets, liquid, injection, inhalers, creams. Do you have any problems with taking medication? e.g. side effects, allergies, difficulty swallowing etc. Any pain relief** Click or tap here to enter text.
	**How you know I'm happy and content?** Click or tap here to enter text. **How you know I am in pain?** Click or tap here to enter text. **What signs do I show?** Click or tap here to enter text.

Name:
NHS:
DOB:

My medical history and treatment plan: Include any previous admissions to hospital, or any previous operations. Details of any family medical history e.g. diabetes etc.
Click or tap here to enter text.

What to do if I'm anxious: Click or tap here to enter text.

Also include:
1) Any triggers Click or tap here to enter text.
2) How you know that I'm anxious Click or tap here to enter text.
3) What to do when I'm anxious. Click or tap here to enter text.

Mental Capacity Act and Advocacy.
Capacity needs to be assumed unless proven otherwise, if the person lacks capacity, capacity will need to be assessed by the health professional proposing the investigation and / or treatment.

Is there anyone who advocates for me? Yes ☐ No ☐

Name: Click or tap here to enter text. **(IMCA, N.O.K)**

Contact details: Click or tap here to enter text.

Does the person have a Health and Welfare Lasting Power of Attorney?

Yes ☐ No ☐

Does the person have an Advanced Statement?

Yes ☐ No ☐

Have you considered the need for a Best Interests Meeting? (MCA Document required)

Yes ☐ No ☐

Have you involved the Community Learning Disability Team?

Yes ☐ No ☐
St Helens CLDT telephone number: 0151 426 5885
Knowsley CLDT telephone number : 0151 426 5885
Halton CLDT telephone number: 0151 511 6606
Liverpool CLDT telephone number: 0151 330 7391

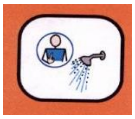
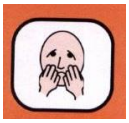
I wish for the information in this passport to be shared with:

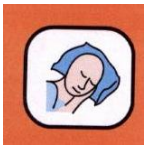
GP ☐ Hospital Staff ☐ Family / Carers ☐

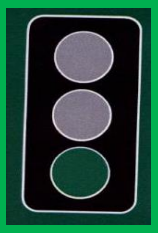
Other health professionals e.g. Dentist etc. Click or tap here to enter text.

Anyone who the information cannot be shared with….. Please specify

Things you need to know about me …

	**How to help me understand things:** Click or tap here to enter text.
	**Moving around (e.g. hoists, bed rails, wheelchair, walking aids, seating and slips / trips and falls, history of falls and how to support me)** Click or tap here to enter text.
	**Personal care: (Dressing and Washing) and how to support me:** Click or tap here to enter text.
	**Behaviour's that may challenge or behaviour that may cause risk (e.g. absconding and how to support me):** Click or tap here to enter text.
	**Seeing / hearing any problems…… and how to support me:** Click or tap here to enter text.
	**More information from:** **Name:** Click or tap here to enter text. **Contact Details:** Click or tap here to enter text.

	**How I eat food (cut up, risk of choking, helping with eating) and how to support me:** **Positioning:(during meal times to reduce risks)** Click or tap here to enter text.
	**How I drink, swallow (small amounts, thickened fluids) and how to support me: Positioning:(during to reduce risks)** Click or tap here to enter text.
	**How I keep safe (support with behaviour that challenges, how long can I be left on my own, is there a need for 1-1 support) and how to support me:** Click or tap here to enter text.
	**How I use the toilet (wear pads, continence aids, promoting to use the toilet, physical support to get to the toilet, incontinent of urine and faeces etc.) and how to support me:** Click or tap here to enter text.
	**Sleeping (sleep pattern, routine, how long does person normally sleep, support to get to sleep, time goes to sleep / awakens normally) Does person need support at night for sleeping? How to support me:** Click or tap here to enter text.
	**Does the person have additional needs whilst in hospital e.g. behaviour that challenges, risk of absconding, lack of awareness of risk / danger (poor impulse control), postural care and support, all of the above needs, needs full support for activities of daily living. If YES…** **How will these needs be met and by whom?** Click or tap here to enter text. **Are additional resources required?** Click or tap here to enter text.



Things you should know about me…

Likes: for example – what makes me happy, what makes me feel safe, things I like to do

Dislikes: For example – don't shout, food I don't like, physical touch.

What's important to me?: Click or tap here to enter text.
How to support me: Click or tap here to enter text.
How I communicate?: Click or tap here to enter text.
How to involve me?: Click or tap here to enter text.
Important people in my life: Contact details Click or tap here to enter text.

Things I like Click or tap here to enter text.	**Things I don't like** Click or tap here to enter text.

Name:
NHS:
DOB:

Hospital Discharge / Information Plan
Name: Click or tap here to enter text.
NHS No: Click or tap here to enter text. **DOB:** Click or tap to enter a date.
Agreed discharge date: Click or tap to enter a date.

Upon admission, consider discharge. Written communication with the following people or agencies as appropriate:

Family / Carers, GP
Community LD Team
Social Worker / Care Manager
Advocate
Discharge Planning Team
Other Click or tap here to enter text.

Please Note Name and Contact Numbers Click or tap here to enter text.

Discharge Plan Checklist

Do you have:

☐ **Summary of what I have been treated for / diagnosed**

☐ **Have my needs changed (e.g. PEG, swallowing, catheter, medication etc)**

☐ **Is equipment needed? Who is providing it?**

☐ **Do my family / carers / support staff need additional training**

Details: Click or tap here to enter text.

Who will provide it?

☐ **List of medication including any changes / additions. Do family / carers / support staff understand what medication is for? How to administer and and side effects?**

☐ **Any follow up appointments?**

☐ **Any other referrals required? To whom?** Click or tap here to enter text.

Who will make the referral? Click or tap here to enter text.

☐ **Any infections / Pressure areas, who is managing these after discharge?**

☐ **How am I getting home from hospital?**

☐ **Please outline any action plan agreed / any other issues.**

☐ **Who was involved in discharge planning, date of discharge planning meeting?**	
Completed by: Click or tap here to enter text.	**Date:** Click or tap to enter a date.