



Somerset
Partnership

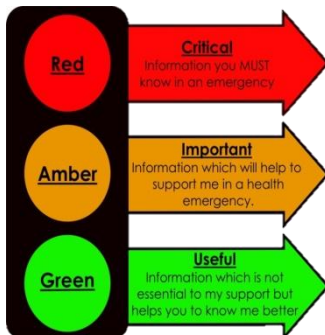
Somerset Partnership



NHS Foundation Trust



Hospital Passport



Red

Critical

Information you **MUST**
know in an emergency

Amber

Important

Information which will help to
support me in a health
emergency.

Green

Useful

Information which is not
essential to my support but
helps you to know me better

Name:

NHS No:

This Hospital Passport is designed to give hospital staff important information about you and about what they need to do to care and support you.

Please take it with you if you have to go to hospital. Ask all staff that look after you to read it and if you need to stay in hospital ask to hang it on the end of your bed and ensure all staff supporting you read it.

Please note: Judgements about quality of life including decisions on resuscitation must be made in consultation with you, your family, carers and other professionals. This is necessary to comply with the Mental Capacity Act 2005.

The Hospital Passport is designed to give information to medical staff in an emergency and provide information when attending appointments and hospital admissions:

The information is the key information staff will need in a medical emergency.
 'My Life Choices / Support Plan' will give more detailed information if the Individual is admitted.

Due to the information needing to be easily assessable in an emergency by medical staff it may not always be written in a format the patient / service user will fully understand.

The patient / service user will always be involved where able in completing the 'Hospital Passport'.

Hospital Liaison Nurse

If there is an 'Acute Learning Disability Liaison Nurse' based at this hospital please ensure you contact them.

The 'Acute Learning Disability Liaison Nurse' will be able to offer specialist support around outpatient appointments, Pre-admission assessments, discharge etc.

Completion of this Hospital passport	Name of person completing form	
	Date	
	Information from	
	Sign	

Personal details

Photo	
Full Name	
Name like to be called	
Date Of Birth	
NHS Number	
Address	
Postcode	
Phone Number	

Doctor

Doctors Name	
Surgery Address	
Postcode	
Phone Number	

Next of kin	Name	
	Relationship	
	Address	
	Postcode	
	Phone number	

Care Management	It is important that my care management team know if I am in hospital so please ensure you contact them		
	Name of Care Management team	Address	Phone no:

Professionals who support me	Name	Role	Contact details

Allergies

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My Beliefs

Cultural & Religious identity

My Religion / Culture	
Religious / Cultural Requests	
Funeral plan in place	
End of life plan	

My Medicines

Name of medication, Reason taken.
How taken (Crushed tablets / Injection/ syrup)with
yoghurt on a spoon etc.

Name of medication	Reason for taking	How taken

Support needed with Medical interventions

e.g. how to take my blood, give me injections, take my temperature, give me my medicines

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Brief medical history

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Known Medical conditions

e.g. Epilepsy, allergies, heart problems, breathing problems, eating & drinking issues

Condition	Details

Behaviour

My behaviours that may challenge or cause risk

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Risks

Keeping me safe , how much I understand

Awareness of safety Is the individual aware of risks to self:	
Freedom of choice Are there any agreed restrictions in place if so what and why? I.e. Only offered low sugar options due to diabetes and lacks capacity to make informed choice otherwise.	
Liberty of movement Are there any DOLS agreements in place for cot side use etc.	

Capacity to Consent

What helps me to make a decision

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Best Interest Decisions

If it is decided I don't have capacity who needs to be involved to make a best interest decision for me?

Do I have an ordinary power of attorney (Finance) or Enduring powers of attorney (medical etc.) in place?

Who should be involved : Family/ Friends/ Staff?

Is an independent mental capacity Advocate (IMCA) needed?

Please use the discharge pack

Notes

Discharge from Hospital

	Yes	No	Don't Know	Details
Communicates verbally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Known preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses a communication Aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uses symbols /Pictures / photos etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can use a telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understanding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
How I express myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Information on capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can tell the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can write	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Things that help me communicate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Eating and Drinking

	independent	Support needed	Don't Know	Details
Eating and using cutlery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drinking and using cups & glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specific dietary requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating and drinking plan from SLT in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Self-care and mobility

	independent	Support needed	Don't Know	Details
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Washing / bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Pain

How do you know
when I am in pain

Mental health

Other useful information

My Likes and Dislikes

Think about – what upsets me, what makes me happy, things I like to do like watching TV, reading, music. How I want people to talk to me. Food I like and don't like. Physical touch, special needs, routines and things that keep me safe.

Things I like	Things I don't like

Somerset Partnership **NHS**

NHS Foundation Trust

Working in partnership with:

Yeovil District Hospital **NHS**
NHS Foundation Trust



NHS
Musgrove Park Hospital