



Hospital Passport

Make sure that all the staff who look after you read this document



This passport gives hospital staff important information about you.

Take it with you if you have to go into hospital.

Ask the hospital staff to hang it on the end of your bed.

Information for hospital staff

Please inform hospital liaison nurses and record date in notes.

Please note: Value 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.

RED ALERT

Things you must know about me

Name:

NHS number:

Likes to be known as:

Date of birth:

Address:

- Living with family and friends
- Privately rented
- Supported accommodation
- Housing association
- Residential home
- Nursing home
- One to one hours in 24hrs
- Shared care hours in 24hrs
- Other

Telephone number:

GP name:

GP address:

GP telephone number:

Next of Kin	Relationship	Telephone
Key worker/main carer	Relationship	Telephone
Professionals involved	Relationship	Telephone
Contact in an emergency	Relationship	Telephone
Religion	Religious requests	

Current medication and medical conditions - e.g. epilepsy, allergies, heart problems, breathing problems, eating and drinking issues, PEG etc.

Brief medical history

Medical interventions - e.g. how to take my blood, give injections, take temperature, medication, BP etc.

Behaviours that may challenging or cause risk:

Level of comprehension/capacity to consent to care and treatment:

Completed by: _____ Date: _____

AMBER

Things that are really important to me

Communication - e.g. how to communicate with me and how I communicate.

Information sharing - e.g. how to help me understand things. For example: easy read, objects of reference. Inform others etc.

Sight and Hearing - e.g. problems with sight or hearing, use of equipment such as glasses, hearing aids etc.

Eating (swallowing) - e.g. food cut up, choking; help with feeding, special equipment.

Drinking (swallowing) - e.g. small amounts, choking, help required, special equipment, thickened drinks.

Going to the toilet - e.g. continence aids, help to get to toilet.

Moving around - e.g. posture in bed, walking aids.

Taking medication - e.g. crushed tablets, injections, syrup, assistance required.

Pain - e.g. how I express pain, for example: verbally, facial expressions, pictures, noises etc.

Sleeping - e.g. sleep pattern, sleep routine, equipment required.

Keeping safe - e.g. bed rails, behaviour, absconding, managing equipment in room.

Personal care - e.g. dressing, washing etc. support required, special needs.

Level of support - e.g. who needs to stay and how often.

Completed by:

Date:

GREEN

Things I would like to happen

My likes and dislikes



Things I like

Please do this:



Things I don't like

Please don't do this:

Think about - what upsets you, what makes you happy, things you like to do i.e. watching TV, reading, music. How you want people to talk to you , for example - don't shout. Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.



Completed by: _____ Date: _____