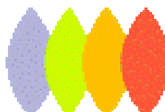
Health and Wellbeing Passport

Name: ………………………………

Name you prefer to be known by: ………………………………

I have (condition/s) ……………

………………………………………



Introduction

The aim of the Health and Wellbeing Passport is to help people involved in the care of someone with long term conditions, understand the impact the conditions has on that person and their resulting needs. It gives important information about you and your carer. Fill in the passport with as much information as you wish.

The passport was originally developed for people going into hospital but you may also want to use it if you go into respite care, or with your GP, community nurses, therapists, ambulance staff and anyone else involved in your care.

Take it with you when you go into hospital and you or your carer can ask the clinical staff to read it and use the information.

The passport is yours, but you may want it to be kept in the nursing documentation so that everyone involved in providing care will be able to see what your needs are during the stay. When you come home your passport should be returned to you.

The passport can be adapted very easily to suit you. For example you can add pages, remove pages that are not relevant to you. Add a plastic folder to place in Appointment Cards, right hand side of prescriptions with the up to date medication on etc. You can even add a picture of yourself.

The Health and Wellbeing Passport was developed by York LINk in association with the organisations shown on the front cover.

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Please read the following pages for important information on how to care for me.

My personal details

My full name is: ____________________

Please call me: ____________________

My address is: ____________________

____

My date of birth is: ____________________

Age: ____________________

Telephone no: ____________________

Mobile: ____________________

Email: ____________________

My occupation is: ____________________

My religion or belief is: ____________________

I live alone: ____________________

I live with: (relative, carer, alone, with other residents etc) ____________________

My NHS number is: ____________________

My hospital number is: ____________________

My GP practice is: ____________________

Tel no: ____________________

Other health information	Name	Tel no
Outpatient appointments		
Occupational Therapist		
Physiotherapist		
Speech Therapist		
Social Worker		
Consultants		
Specialist Nurse		

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Carer, Power of Attorney, Next of kin

My carer's name is: ______________________________

Their address is: ______________________________

Telephone no: ______________________________

Mobile: ______________________________

Email: ______________________________

They are my next of kin (please circle): Yes No

If no, my next of kin is: ……………………………………………………………….

Name: ………………………………………………………………………………

Contact: ……………………………………………………………………………….

My Advocate is (e.g. from OCAY, Care Manager, Minister)

……

There is a financial Power of Attorney for me: Yes No (please circle)

There is a welfare Power of Attorney for me: Yes No (please circle)

Reference number: ………………………………………………………………….

It/they are held by: ………………………………………………………………….

Name: ………………………………………………………………………………

Phone no: ……………………………………………………………………………..

Mobile: ………………………………………………………………………………...

They also hold for me a (please circle)

Living Will or Advanced Decision or Donor Card

A copy of my Living Will or Advanced Decision
is attached. (please circle) Yes No

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I want my carer to be involved in (please circle):

Feeding me: Yes No

Washing me: Yes No

Dressing me: Yes No

Continence needs: Yes No

Mobility needs: Yes No

I also want my carer to be involved in my discharge from hospital (please circle):

Yes No

I give my consent to involve my carer in decisions for me if I am unable (please circle):

Yes No

Signature and date of carer and cared for person

Carer: ………………………………….. Date: ……………………………………………

Cared for person: …………………….. Date: ……………………………………………

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These are the people who support me on a regular basis

People who support could include family members, friends, neighbours, health and social care staff or professionals.

Name	Address	Tel No	Relationship

I give consent for the above named people to receive information about my (please circle)

Diagnosis Treatment Prognosis

I have made the above named people aware of this.

Signature: …………………………………. Date: ……………………………………

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My medications at the moment are

Name	Dose	Times

Date: ………………………………………………………………………………….

I am allergic to: …………………………………………………………………..

……………………………………………………………………………………….

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I have the following problems with taking medications:

	Yes	No	Sometimes
Difficulty swallowing			
I don’t want to take it			
I forget to take it			
I worry about the side effects			
I use a medidose system at home			
I need to eat with medication			

I use the following compliance aid: ………………………………………………..

……………………………………………………………………………………………….

I need the following assistance to take medications: ……………………………

……………………………………………………………………………………………….

Important information about medication: …………………………………………...

……………………………………………………………………………………………….

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My pain management needs

When I am in pain I get: (please circle)

Upset　　Withdrawn　　Angry

Shout　　Cry　　Other

I usually manage pain by: (please circle)

Using a tens machine　　Taking medication

Moving my limbs　　Lying quietly

The best time of day for me is usually: (please circle)

Morning　　Afternoon　　Evening

Other important information about my pain management:

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My nutritional needs

	Yes	No	Sometimes
I am unable to eat and/ or drink			
I need assistance with eating			
I need assistance with drinking			
I prefer cold drinks			
I like tea coffee (please circle) milk yes no (please circle) and............sugars			

I need to use: (please circle)	Specialist cutlery	Beaker	Cup	Straw

I can eat a (please circle)

Normal Soft Pureed Liquid diet

I am allergic to/have intolerance to the following food or drink: ……………….

…………………………………………………………………………………………

I do not like the following foods: …………………………………………………..

…………………………………………………………………………………………….

I need dentures to eat (please circle)

Yes No

Other important information about how I eat or drink: …………………………...

…………………………………………………………………………………………….

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My communication needs (please circle)

I wear glasses	Yes	No
I wear contact lenses	Yes	No
I wear a hearing aid	Yes	No
My speech is always clear	Yes	No

I use the following equipment to help me speak: ……………………………….

…………………………………………………………………………………………….

Things I like or which comfort or relax me are: ……………………………………

…………………………………………………………………………………………….

Things I don't like or which upset me are: ………………………………………….

…………………………………………………………………………………………….

I am often better at communicating at the following time of day: ………………

……………………………………………………………………………………………

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My mobility needs

	Yes	No	Sometimes
I have no mobility			
I can walk unaided			
I need help with walking			
I use a walking stick			
In use a Zimmer frame			
I use a wheelchair			
I can tell you when I need help with mobility			
I need a hoist to help me move			

I wear the following equipment to help me mobilise: ……………………………..

……………………………………………………………………………………………….

At home I have the following hoist and sling: ……………………………………..

……………………………………………………………………………………………….

Important information about how I mobilise: ……………………………………….

……………………………………………………………………………………………….

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My toileting needs

	Yes	No	Sometimes
I am fully continent			
I have urinary incontinence			
I have faecal incontinence			
I need to be asked to go to the toilet			
I need to get to the toilet quickly when necessary			
I wear pads to help me with continence			
I suffer from constipation			
I suffer from diarrhoea			
I wear a urinary catheter			

I need the bag emptied approximately every................hours

I self catheterise		
I wear a sheath and bag		

Important information about my toileting needs: ....

....

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Other information about me

To help me with breathing I use a (please circle):

Nebuliser Inhaler Volumatic Other

I have a pet ……………………………at home

	Yes	**No**
I have difficulty sleeping		
I use .... pillows to help me sleep		
I need a bed cradle		
I need cot sides		
I get tired easily		
When I am at home, I usually need help with washing and dressing		
I prefer to have a (please circle)	bath	Shower

Other important information about me: ……………………………………………

………………………………………………………………………………………

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	My daily routine is usually
Time:	Activity:

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This is a record of the people who have read this document	
Date:	Name and designation e.g. nurse:

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My medications at the moment are

Name	Dose	Times

Date: ………………………………………………………………………………….

I am allergic to: ……………………………………………………………………...

…………………………………………………………………………………………….

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…………………………………………………………………………………………….

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DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNARadult.1(March 2009)

Name	
Address	
Date of birth	
NHS or hospital number	

Date of DNAR order:

/ /

PLEASE KEEP ORIGINAL IN COLOUR

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?" If "YES" go to box 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. YES / NO

All other decisions must be made in the patient's best interests and comply with current law.
Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional completing this DNAR order and forwarding form to Ambulance Trust ☐

Name ____________ **Position** ____________

Signature ____________ **Date** ____________ **Time** ____________

7 Review and endorsement by most senior health professional:

Signature ____________ **Name** ____________ **Date** ____________

Review date (if appropriate)

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