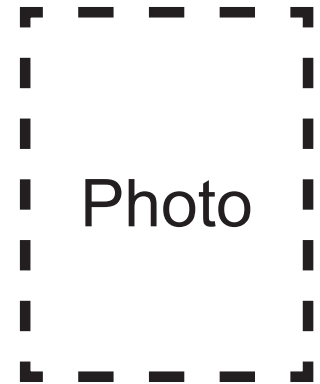




Date completed:

.....

**My**  
**Health**  
**Passport**



Please read this assessment to get to know me. It contains important information about me.






My name is

I like to be known as


My DOB and NHS no

This health passport belongs to me. Please return it when I am discharged.

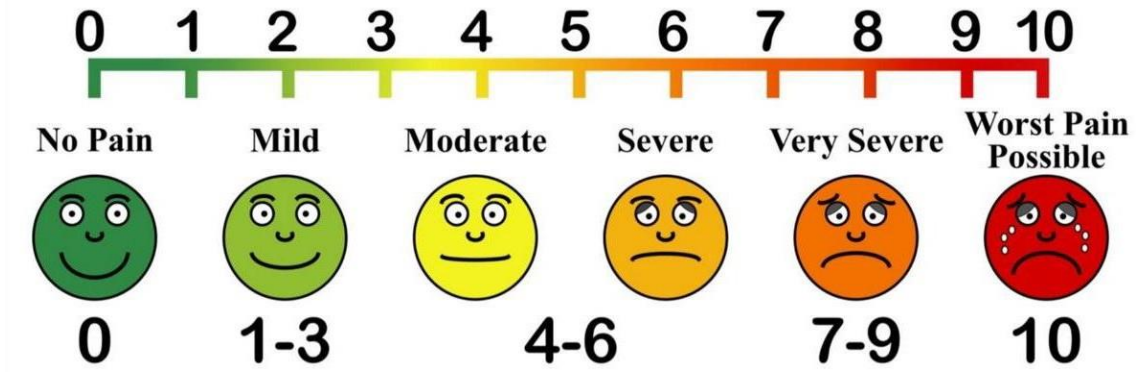
**FOR HOSPITAL ADMISSIONS:** Please keep a copy of my health passport with my nursing file at the end of the bed. Please also inform the Learning Disability Hospital Liaison Nurses that I am here and record the date in my notes. **I give consent for information about me to be obtained from and/or shared with other agencies / health professionals.** Yes  No

	<p>My preferred <b>communication method</b> to help me understand:</p> <p>✓ <b>Tick boxes which apply</b></p> <p><input type="checkbox"/> Speaking      <input type="checkbox"/> Signing      <input type="checkbox"/> Pictures</p> <p><input type="checkbox"/> Using objects      <input type="checkbox"/> Inform others      <input type="checkbox"/> Easy Read</p> <p>Other communication methods I find helpful:</p>
	<p>If I am admitted to hospital, I require the following <b>reasonable adjustments</b>. </p>

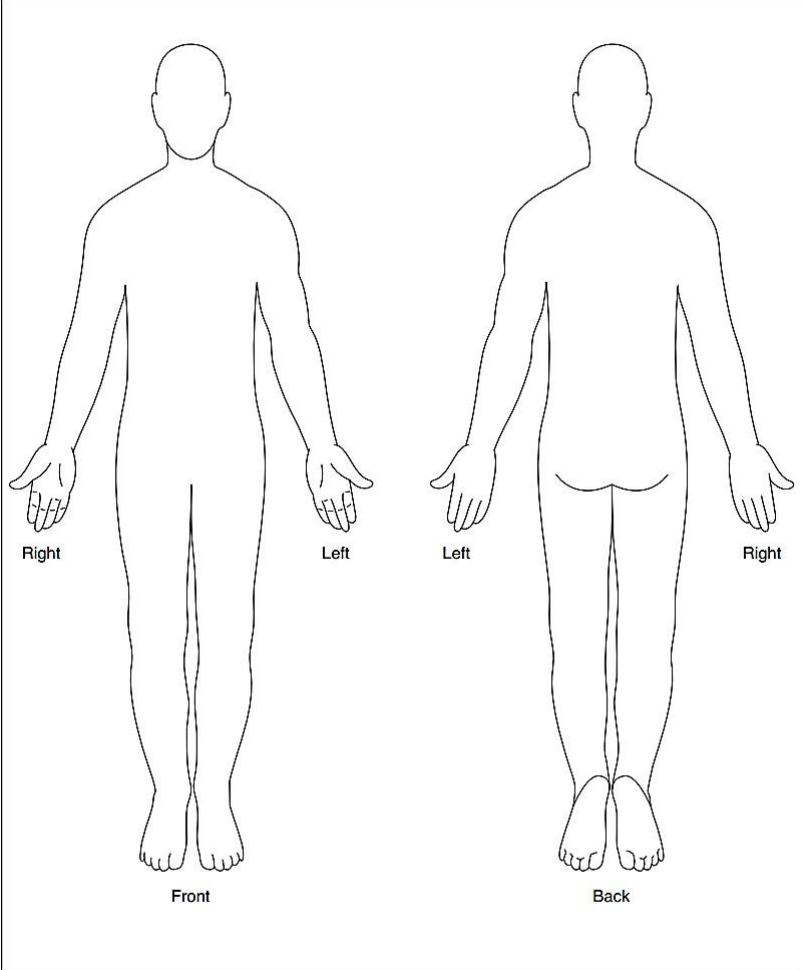
# My normal observations

	Date Completed and Name of Clinician ..... .....	Blood Pressure: Sitting.....Standing .....
		Blood oxygen level ..... Temperature ..... Breathing rate ..... Weight ..... Height .....

**This section is to be used by Clinical Staff only. No need for you to complete - move on to page 3.**



Additional assessment tool for Clinical Staff if the patient is admitted to hospital and unable to express their pain.



## How to help me if I am anxious



## How will you know if I am in pain (eg: verbally, facial expressions, pictures, noises)



## How will you know if I am unwell (eg: stop drinking, calling out, being quiet)



## How to take my blood, give injections, blood pressure etc



## My medical history



## How I take my medication







✓ Tick boxes which apply

- with water
- liquid
- via PEG





- crushed tablet
- dosette box
- other

- injection
- blister pack





## Things you must know about me

	<input type="checkbox"/> I live with family and friends <input type="checkbox"/> In my own house or flat <input type="checkbox"/> In supported accommodation	<input type="checkbox"/> Housing Association <input type="checkbox"/> Residential home <input type="checkbox"/> Nursing home	<input type="checkbox"/> One to one hours in 24 hrs <input type="checkbox"/> Shared care hours in 24hrs <input type="checkbox"/> Other
	Name of the person who cares for me		
	Relationship		
	Their telephone number		




## Next of Kin (this is your closest living relative)

	Name	
	Relationship (e.g Mum or closest relation)	
	Their address	
	Their telephone number	




## Emergency or first point of contact

	Name	
	Relationship (e.g Dad)	
	Their address	
	Their telephone number	









## My GP contact details

 GP Surgery	GP name	
	GP surgery	
	GP telephone number	

## My contact details

	My address	
	My telephone number	
	My email address	

## Things you must know about me

	<p>I have epilepsy</p>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	<p><input type="checkbox"/> epileptic and / or <input type="checkbox"/> non-epileptic attacks</p>
	<p>I have allergies</p> <ul style="list-style-type: none"> <li>•What are they?</li> <li>•What does the reaction look like?</li> </ul>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	
	<p>I have heart problems</p> <ul style="list-style-type: none"> <li>•What are they?</li> </ul>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	
	<p>I have breathing problems (e.g respiratory)</p> <ul style="list-style-type: none"> <li>•What are they?</li> </ul>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	
	<p>I have diabetes</p>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	<p><input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2</p>
	<p>I have a feeding tube</p>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	
	<p>I have eating and drinking guidelines in place</p> <ul style="list-style-type: none"> <li>•Food level?</li> <li>•Fluid level?</li> </ul>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	
	<p>Do you have an End-of-Life plan?</p>	<p>Yes ✓ <input type="checkbox"/> or No ✗ <input type="checkbox"/></p>	

**Other services or professional involved in my care  
(or nominated advocate)**



Please give name, job title and contact details 📞 for each service or professional or nominated advocate.



1.

2.

3.

4.

5.

## Daily Activities

	<p><b>Keeping safe</b> e.g. bed rails, behaviour, managing equipment, running away.</p>	
	<p><b>Level of support</b> e.g. what level of support do you have at home.</p>	
	<p><b>Support I need with dressing</b> e.g. washing, special needs.</p>	
	<p><b>Sight and hearing</b> problems e.g. glasses, hearing aid.</p>	
 <p style="text-align: center;">Drink</p>	<p><b>Support I need with drinking</b> e.g. ordinary cup or special equipment, small amounts, help required, thickened fluids.</p>	
 <p style="text-align: center;">Eat</p>	<p><b>Support I need with eating</b> e.g. food cut up, help required, special equipment, pureed food.</p>	
	<p><b>Going to the toilet</b> e.g. help required to get to the toilet, continence aids – pad size.</p>	
	<p><b>Help with moving around</b> e.g. walking aids, hoist transfer, wheelchair.</p>	
	<p><b>Sleeping</b> e.g. posture in bed, sleep pattern, sleep routine, equipment required.</p>	
	<p>Important routines.</p>	
	<p>Religion, cultural or spiritual needs.</p>	



## Mental Capacity Act 2005 - For people aged 16 and over

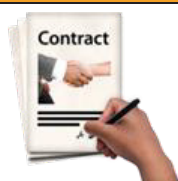


If a person is assessed as lacking the ability to make a decision and needing an advocate, please follow local Mental Capacity Act Policies and Mental Capacity Act Code of Practice. If I am assessed as lacking the capacity to consent to my treatment, the following people must be involved in any decisions made in my best interest.

Name	Relationship	Contact details

Do you have a Lasting Power of Attorney or Deputyship?

Yes ✓  or No ✗



This is a legal document that lets you appoint someone to help you make decisions.

Name, relationship and contact details



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## My current medication list

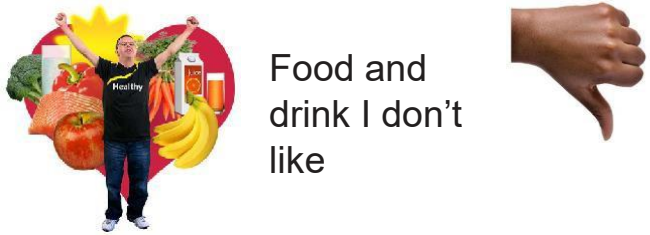


Attach a copy of your current list of prescribed medication.  
e.g. MAR chart or GP repeat prescription

# Likes and Dislikes - what will help in a hospital setting

 <p><b>Things I like that make me happy, safe and comfortable</b>          e.g. things I like to do          - watching TV, reading, music, leisure activities.</p>	 <p><b>Things I don't like that make me sad</b>          e.g. things that upset me          - don't shout, physical touch, restraint.</p>
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 <p><b>Food and drink I like</b></p>	 <p><b>Food and drink I don't like</b></p>
---	--




## Me at my best

This is me on a good day

E.g. body language, vocal signs, eye contact, skin appearance

When I am feeling well at home I am:



### I have difficulty with

- writing
- moving

- self-care
- controlling my behaviour



## Additional Information

Reasonable adjustments or special / sensory needs



## Making a recommended summary plan for emergency care and treatment (ReSPECT)



The ReSPECT form is a short plan about what should happen if you need health care or treatment in an emergency. Understanding what matters most in your life helps to make a better plan.

Do you have a ReSPECT form?  Yes  No



For ReSPECT Easy Read guides:  
<https://www.resus.org.uk/respect/respect-resources>



For ReSPECT films:  
[www.resus.org.uk/respect/respect-patients-and-carers](http://www.resus.org.uk/respect/respect-patients-and-carers)

To download a copy of The Hospital Communication Book:  
visit [www.ghc.nhs.uk](http://www.ghc.nhs.uk) then search 'Hospital Communication Book'  
There are lots of EasyRead guides about healthon:  
[www.easyhealth.org.uk](http://www.easyhealth.org.uk) or [www.apictureofhealth.southwest.nhs.uk](http://www.apictureofhealth.southwest.nhs.uk)

Produced by the Learning Disability Health Facilitation Team 2020 following consultation with Learning Disability partners in Gloucestershire Hospital NHS Foundation Trust, All Disability Provider Forum and a county survey. Update based on the original work by the former Gloucestershire Partnership NHS Trust. Images courtesy of Photosymbols.

Review: September 2025