

My

Learning Disability

Hospital Passport

Photo of person

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| **Name:**  |   |
| **I like to be known as:**  |   | **Pronouns (she/he)** |  |
| **Date of birth:**  |   | **NHS No:**  |   |

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| **Allergies:**  |  **Please read this document to get to know me, it contains important information.**  |

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| **Address:**  |   |
| **Phone number:**  |   |
| **Email Address:**  |   |

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| **GP Practice:**  |   |
| **GP name:**  |   |
| **GP phone number:**  |   |

**Mental Capacity Act**

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.

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| **Important people to me** - This could be family members, carers or members of the care team and **who can support with a best interest decision**  |
| **Name #1:**  |   | **Relationship:**  |   |
| **Phone Number:**  |   |
| **Please Tick if this person is your:** LPA: ☐ **OR** Deputy for Health and Welfare: ☐ **AND/OR** Next of Kin: ☐  |
| **Name #2:**  |   | **Relationship:**  |   |
| **Phone Number:**  |   |
| **Please Tick if this person is your:** LPA: ☐ **OR** Deputy for Health and Welfare: ☐ **AND/OR** Next of Kin: ☐  |

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| **RESPECT -** *please tick*  |
| I **have** a RESPECT form **☐** I **do not have** a RESPECT form **☐**   |
| If I do not have a RESPECT form or Advanced Decision, please discuss this with me and check ICR  |

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| **How to help me if I am anxious / becoming upset** | **How do you know if I am in pain / distress** |
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| **Medical history** *information about my health / diagnosis* | **How do you know if I am unwell?** |
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| **Baseline observations** *When I am healthy and at home* | **Behaviours on baseline:** |
| **Blood pressure:**  |   | **Pulse:**  |   |  |
| **Temperature:**  |   | **Breathing rate:**  |   |

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| **How I take my medication** |
| **Oral** **☐**  | **Crushed tablets** **☐**  | **Injection** **☐**  | **Syrup/Liquid** **☐**  |
| **Dossett Box** **☐**  | **PEG** **☐** | **No drink** **☐** | **Other** **☐** |
| **Other:**  |   |  |  |

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| **How I have medical Interventions** *how to take my blood, give injections, blood pressure etc.* |
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| **Support at home**  |  |  |  |
| **Living alone** **☐**  | **Living with family/friends** **☐**  | **Supported living** **☐**  | **Residential home** **☐**  |
| **Extra care housing** **☐**  | **LD nursing home ☐**  | **General nursing home** **☐**  |   |
| **Other:**  |   |  |  |

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| **How I communicate** |
| **Speaking** **☐** **Signing** **☐** **Pictures** **☐** **Using objects** **☐** **Easy read** **☐**  | **Other:** *opportunity to write individual communication needs*  |

**If patient is being put under anaesthetic, please consider extra interventions that could be under done to reduce distress for the patient (Bloods/Nail Cutting etc)!!!**

Tick if Separate Care Plan Relevant

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| **Keeping safe** *e.g. bed rails, behaviour, managing equipment*  |   |
| **Daily Living Skills** *e.g. washing, dressing etc.*  |   |
| **Help with moving around** *e.g. walking aids, hoist transfer, equipment*  |   |
| **Support I need with eating** *e.g. eating and drinking guidance, ask for separate guidelines*  |   |
| **Support I need with drinking** *e.g. ordinary cup or special equipment, small amounts, help required, thickened fluids*  |   |
| **Going to the toilet** *e.g. prompting, continence aids – pad size, bowel routine, constipation*  |   |
| **Sensory or Behavioural** *e.g.**sensory triggers or needs.*  |   |
| **Sight and hearing problems** *e.g. glasses,* *hearing aid*  |   |
| **Oral Care & Dental** **Hygiene**   |   |
| **Sleeping** *e.g. posture in bed, sleep pattern, sleep routine, equipment required*  |   |
| **Important routines**  |   |
| **Religion, cultural or spiritual needs**  |   |
| **Access to technology** *e.g. do they have a phone/tablet/computer?*  |   |

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| **Things that make me happy, safe and comfortable** e.g. pets, watching TV, reading, music, books  | **Things that can cause me to become upset or anxious** e.g. loud noises, physical touch, busy places  |
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| **Food and Drink I like**  | **Food and Drink I don’t like**  |
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| **Contact details of learning disability services:**  |
| **Complex Health Needs Service****Phone: 01225531566** **Email:** **BATHNES.CHNSAdmin@hcrgcaregroup.com** |
| **RUH Learning Disability and Autism Liaison Team.****Phone: 01225 824246****E-mail:** **ruh-tr.learningdisabilities@nhs.net** |

Produced by the Complex Health Needs Service in conjunction with the RUH Learning Disability and Autism Liaison Team. Based on the work done by the adult learning Disability Health Service following consultation with Bristol, North Somerset and South Gloucestershire community and acute services and in partnership with People First. and by the former Gloucestershire Partnership NHS Trust.

Please ask your local Learning Disability team if you would like this passport in an easy-to-read format.



**Name: DoB: Date completed: Page 5 of 5**

**Discharge**

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|  | **Have the patient/family/carers all been involved in discharge planning?** |
|  | **Have the discharge liaison team been made aware?** |
|  | **Are Social Care involved?**  |
|  | **Is a new Care Act Assessment required?**  |
|  | **Have the TTa’s been organised?** |
|  | **Have there been medication changes? (or branding changes)** |
|  | **Have the changes been explained to the patient/carer?** |
|  | **Have any new diagnosis been given?** |
|  | **Have the new diagnosis been explained accessibly?**  |
|  | **Has there been a change in mobility?** |
|  | **Does the patient need new equipment?** |
|  | **Have there been care/support changes?** |
|  | **Have any referrals been made?**  |
|  | **Are any follow ups required?** |
|  | **Has the discharge summary been given to Patient/carers?** |

**Summary/Notes:**

**What is the route of discharge?**

**Name: DoB: Date completed: Page 5 of 5**

**Name: DoB: Date completed: Page 5 of 5**

Summary/Notes:

**Name: DoB: Date completed: Page 5 of 5**