

“The Patient Passport”

RED

AMBER

GREEN

This gives hospital staff important information about you.

Please take it with you if you have to go into hospital.

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

Make sure that all the staff who look after you read it.

Note for Staff -
remember the Men-

Hospital
Please remember the 5 points in tal Ca-

capacity Act (2005)

RED - ALERT

Things you **MUST** know

about me

Name:

Male ☐

Female ☐

Organ Donor ☐

Prefers to be called:

Do you need an interpreter? Yes ☐ No ☐

NHS No.:

Address:

Tel No:

Date of Birth:

Doctor:

Address:

Tel No:

Next of Kin:

Relationship:

Tel No:

Relevant Person/Carer:

Tel No:

Other Professional/Advocate:

Tel No:

Religion:

Religious preferences:

Is there anyone you would like hospital staff to talk to about your treatment? Yes ☐ No ☐

Is there anyone you would like to help you with your care whilst you are in hospital?

(e.g. carer, parents — add names here)

Yes ☐ No ☐

MEDICAL HISTORY

Have you got problems with any of the below:

Blood Pressure ☐

Diabetes ☐

Heart ☐

Breathing ☐

Bladder/Bowels ☐

Allergies ☐

Swallowing ☐

Epilepsy ☐

Skin Integrity ☐

Anxiety (behaviour) ☐

Hearing ☐

Vision ☐

Mobility/Falls ☐

Dementia ☐

Thyroid ☐

Other:

Please list:

If any of the above ticked please give details:

Current Medication:

(Please bring along your MARS Sheet if possible)

Brief medical history:

Completed by:..... Date:.....

AMBER – ALERT

This is a signpost
to further
information

Things that are really important to me

Communication

How to communicate with me and how I communicate with you.



Taking medication

Crushed tablets, injections, syrup; how to take my blood.



Information Sharing

How to help me understand things.



Pain

How you know I am in pain



Seeing/Hearing

Problems with sight or hearing



Sleeping

Sleep pattern, sleep routine, sleep system.



Eating/Drinking (Swallowing)

Food cut up, small amounts, choking, help with feeding, PEG Management plan, feeding aids.



Being safe

Bedrails, posture, supporting behaviour, absconding.



Going to the toilet

Continence aids, help to get to the toilet, assistance, bowel frequency



Personal Care

dressing, washing etc



Moving around

Posture in bed, hoists/slides, walking aids.



Level of support

Who needs to stay and how often.



Completed by:..... Date:.....

AMBER – ALERT



This is a signpost
to further
information

	Further Plans in place
My Preferred Priorities for Care should my physical health get worse. How and where I would like to be looked after:-	<input type="checkbox"/>
I have a Lasting Power of Attorney (LPA) - Yes <input type="checkbox"/> No <input type="checkbox"/> My Lasting Power of Attorney relates to (please tick one):- Health Welfare and Treatment <input type="checkbox"/> Finances <input type="checkbox"/> Both of these <input type="checkbox"/>	<input type="checkbox"/>
I have an Advance Decision (please tick one) Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>

GREEN

LIKES / DISLIKES

Things that will make a difference to me during my stay in hospital

 <h3>THINGS I LIKE</h3>	 <h3>THINGS I <u>DON'T</u> LIKE</h3>
<p>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 (don't shout). Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.</p>	

Completed by:..... Date:.....