Completed	by:	Date
-----------	-----	------

This is my

Hospital Passport

Name:
DOB:
NHS number:
Address:



I have a PAC plan (advanced care plan)
Yes □ No □

I have an emergency care plan Yes \square No \square

My hospital passport helps doctors and nurses know all about me.

My passport comes with me when I go to my clinic appointments and if I go to Hospital.

My passport stays by my bedside and goes home with me.

Completed by:	Date
Important information about me	e
I like to be called:	•••••
my parents/guardians ar	e:
	•••••••••••
	•••••••••••
My contact phone number	ers:
	••••••••••••
	••••••••••••
Who do I live with?:	
••••••	•••••••••••
•••••	•••••••••••••••
•••••	•••••••••••••••
Who gives consent about my	y care (parent/guardian)
My allergies	

My spiritual/religious needs

Comi	oleted b	γ:	Date
COIIII	Jicica D	y · · · · · · · · · · · · · · · · · · ·	Date

Important information about me



My GP details



My Hospital Consultants

Other professionals involved in my care (physio, dietician, SALT, dentist etc.):



My Social worker is:

Completed by:	Date
---------------	------

Important information about me



How to communicate with me (first language, PECS etc.):

My breathing (I do/do not have ventilation or oxygen at home):

How do I eat & drink? (Thickener, cut up, NG) How do you know if I'm hungry/thirsty?

How I take my medicines (crushed tablets, injections, syrup, by mouth, feeding tube:

Important information about me



Surgery I have had (what and when):



How do you weigh, take blood pressure or take bloods on me?:

Cam	alatad by	/:	Data
COIII	טופופט שי	/	Date

How to look after me

How do you know if I'm uncomfor	table or scared	?:
How do I move around? (Wheelch	air, hoist, frame	e etc.):
How is my vision/hearing?	Glasses □	Hearing aids □
How do I wash / dress?		

How to look after me



How to keep me safe? (Supervision need, bed rails etc.)



How do I use the toilet?

How do I sleep? (routine etc.)



Anything else important to me?

My likes and dislikes

<u>Likes</u>	\odot	<u>Dislikes</u>	

Completed by:	Date
---------------	------

Medicines

Please keep this list up to date, by crossing off any medications when no longer used.

Please re-write medicines when the dose is changed. More medication sheets can be obtained from you consultant's secretary.

Medication & strength (mg per ml)	Dose (mg or ml)	How many times per day	Route (mouth, NG)	Date started	Date stopped

Medicines

Medication & strength (mg per ml)	Dose (mg or ml)	How many times per day	Route (mouth, NG)	Date started	Date stopped

[&]quot;This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg"