This is my...

Barnsley Universal Health Passport

Making healthcare safe and personal

Upload Photo

My name is:

I like to be called:

Healthcare staff, please consult this passport before you assess me or carry out any interventions.

Treat me well

This document belongs to me. Please make sure I take it with me when I leave my appointment or when I am being discharged.

This is an information document NOT a decision-making tool.

Information within this passport has been gathered from people who know me well. Please check this document for when this information was last updated and confirm any important information.

Date this passport was completed:

This passport should be updated if anything changes.

Annual Review Date:

Guidance / Additional Information for My Health Passport

This passport is intended to help healthcare staff provide you with care.

Mental Capacity

Always remember you must ask for my consent for any care and treatment, unless there is a reason to question my ability to make decisions. If so, please assess my capacity in line with the Mental Capacity Act (2005) and use the least restrictive options to meet my needs (Best Interests).

If I lack capacity to make any decisions about my health and social care, a Deprivation of Liberty Protection Safeguards (D.o.L.S) must be considered.

Top Tips

Passport owners
Please remember to take your medication with you if you are going to hospital

Health and social care professionals
Please refer to this document for description of my diagnosis and condition

My personal information

Date of birth: NHS Number:

Home Address:

Telephone:

Ethnicity:

Religion and religious needs:

☐ I recieve care and support from someone called:

Relationship to me:

Please contact my carer to keep them informed: ☐ Yes ☐ No

Name: Telephone:

☐ I provide care and support for someone called:

Relationship to me:

My caring responsibilities for the person I provide unpaid care and support for are:

The person I provide care and support for will need assistance if I am not around:

☐ Yes - Please see key contacts and emergency contacts ☐ No

Key contacts and emergency contacts

Contact 1

Name: Telephone:

Email: Relationship:

Contact 2

Name: Telephone:

Email: Relationship:

Contact 3

Name: Telephone:

Email: Relationship:

Diagnosis and conditions that I know about:

Please check with my GP for details

Name: Telephone:

Reasonable adjustments

If I become distressed, try this: (e.g. I need a quiet space such as a side room away from noise)

My likes and dislikes

Likes: For example – What makes me happy? What do I enjoy doing? E.g. watching TV, reading, listening to music, my routines, talking to people.

Dislikes: For example – What makes me sad? What do I not like? E.g. shouting, being told what to do, food I do not like, physical touch.

Things I like (please do these):

Things I don't like (please don't do these):

How I communicate

How I communicate and what language I speak:

Please check if I use anything to help me communicate e.g. pictures, MAKATON

How I say hello:

Sensory information e.g. sight, hearing and touch:

How I show I am happy or unhappy:

How I say I am hungry:

Food, drink and dietary requirements

The foods that I like (including any dietary requitements):

The foods that I don't like:

Food allergies:

How I eat (help to cut up food, risk of choking, swallowing and other help I need to eat):

How I say I would like a drink and my favourite drink:

How I drink (usual quantities, thickened fluids, likes and dislikes):

My medication, health and care needs

How I usually take my medication (tablets, injections and/or liquid):

Allergies:

Heart or breathing problems:

Medical interventions – (e.g. how to take my blood, give injection, take blood pressure etc):

How do you know I am in pain and where is the pain?

How I usually use the toilet (continence aids, help getting to the toilet, etc):

Moving around (posture in bed, walking aids, transferring, etc)

Help I need with personal care (washing, dressing, etc):

Sleeping (Sleep pattern/routine):

Pressure care (any support I need with this):

How I keep safe (bed rails, support with challenging behaviour, etc):

Sensory needs (do I struggle with light, noise, crowded areas, etc?):

My other support needs

My support needs and who gives me the most support:

Managing my affairs

I have Lasting Power of Attorney: ☐ Yes ☐ No

If **yes**, please talk to:

Name: Telephone:

I have a Court Appointed Deputy: ☐ Yes ☐ No

If **yes**, please talk to:

Name: Telephone:

I have an Enduring Power of Attorney for Health and Wellbeing: ☐ Yes ☐ No

If **yes**, please talk to:

Name: Telephone:

Other key contacts:

Name	What support does this person provide (e.g. Dietician)	Contact details

Notes:

Notes (continued):

Barnsley Hospital NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust

Barnsley Healthcare Federation

Yorkshire Ambulance Service NHS Trust

BARNSLEY Metropolitan Borough Council

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