This booklet has been designed to help people with chronic illnesses and long-term disabilities communicate their needs to medical professionals, particularly when entering a clinical or hospital setting as an inpatient.

Whether someone has been living with illness or disability for a long time or is just getting to grips with a dramatic change in their health, it can be challenging for doctors, nurses, and support staff to understand their history. Many patients become overwhelmed by the complexity of their ever-evolving treatments and diagnoses, get frustrated or fatigued when repeating themselves, or struggle to articulate the details while acutely symptomatic.

The person to whom this booklet pertains is so much more than the sum of the ailments contained within, but we hope that having the information outlined clearly and concisely will make the admission process easier; for both the patient and their medical team.

Version 01.5

UK/Eire Edition

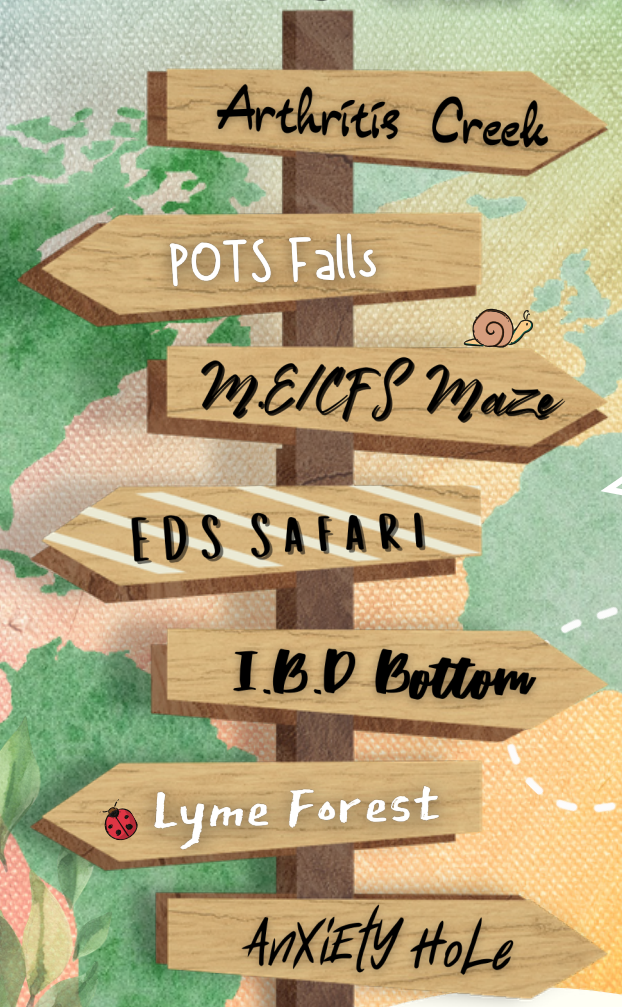
Aa
Standard Print Edition

CONTACT US

If you have any queries or suggestions please email:
ChronicHealthCarePassport@gmail.com

Find our top tips & tutorials for completing your CHP or download extra pages, blank copies, accessible editions, and posters, here:
tinyurl.com/MyChHcPp

My Chronic Health & Care Passport



D.O.B .....

NHS NUMBER .....

NAME .....

LAST REVIEWED/UPDATED .....

Guide

How to fill in your Chronic Health & Care Passport and where to find hints and tips if you need them.

What is My Chronic Health & Care Passport for?
My Chronic Health & Care Passport (MCHCP) is a set of patient-held medical history notes designed to help patients keep track of multiple, complex illnesses and/or disabilities and communicate their needs to medical teams and carers, especially on admission.

How do I use it?
By filling in your MCHCP and - very importantly - keeping it as up to date as possible, you will have a clear record of your health and care needs. If you are admitted to hospital or are getting to know new carers, you may find it useful to refer them to specific pages to help you explain how they can help you. There are also pages that will help you pack for a hospital admission, or work out what to ask at your next appointment.

Tips for filling it in:
-Use printable stickers or complete your MCHCP in pencil or erasable pen (eg: FriXion) if your medication, health, or care needs change a lot and need to be regularly updated or re-written.
-Print out as many extra 'My Conditions' pages as you need.
-If you have to make lots of corrections, re-print only the pages you're updating. This will be cheaper, easier, and more sustainable.
-Use the blank, untitled, custom pages to create your own categories and then add them to the Contents page. You could use it for *Likes & Dislikes, Spiritual/Cultural Needs*, detailing your *Power of Attorney arrangements, Living Will/DNAR wishes*, or for outlining your current *Physiotherapy Regimen* or *Treatment Plan*.

Where can I find out more?
For more information, extra pages, other versions of the passport, and a full FAQ, please visit our website: tinyurl.com/MyChHcPp

Helplines

Support services and organisations who might be able to help when you need it.

Samaritans - www.samaritans.org - Tel: 116 123 (24/7)
Emotional support for people who are distressed.
Postal Address: Chris, Freepost RSRB-KKBY-CYJK, PO Box 9090, Stirling, FK8 2SA. Or Email: jo@samaritans.org

Shout - Text: text SHOUT to 85258
Support if you're experiencing a personal crisis & are unable to cope.

C.A.L.M. - www.thecalmzone.net - Tel: 0800 58 58 58 (5pm – midnight) Phone (for callers within London area): 0808 802 5858
Emotional support, advice, and information for men who are feeling suicidal, and their families.

Scope - www.scope.org.uk - Tel: Phone: 0808 800 3333
Textphone: dial 18001 then 0808 800 3333. (Freephone if in UK.)
Providing free, independent, impartial advice and support to disabled people and their families. Email: helpline@scope.org.uk.
Language Translation and BSL video calls also available if required.

The Advocacy People - www.theadvocacypeople.org.uk
Tel: 0330 440 9000 or Text 80800, starting message with PEOPLE
info@theadvocacypeople.org.uk
Helping anyone who needs independent support to speak up. They can help with medical, care, & MH advocates, people lacking capacity, official healthcare complaints, and more.

Trussell Trust - www.trusselltrust.org/get-help - Tel: 01722 580180
Search on website for nearest foodbank. Providing a minimum of three days emergency food and support to people experiencing crisis in the UK. Vouchers available from Social Services and CAB.

The Cinnamon Trust - https://cinnamon.org.uk - Tel: 01736 757 900
Practical support for elderly, ill, or disabled pet owners in need.

Self-Care Crisis Plan

Write down the things that help give you strength, so that you always have them with you.

Who should I call?

Name: .....

Contact: .....

Name: .....

Contact: .....

Name: .....

Contact: .....

What can I do to keep myself safe? What has worked before?

.....

.....

.....

.....

What soothes me or helps give me the strength to keep going? What good memory helps me to hold on and ask for help?

.....

.....

.....

.....

.....

A message to myself. "This too will pass."

.....

.....

.....

Even if you have added extra pages, the sections are colour-coded to help guide you to them.

Contents

Guide & Contents

About Me & Carers

Medication & Allergies

Medical History & Surgical History

Ability Aids & Assistance

Dietary Requirements & Preferences

Pain & Mobility

Mental Health

Recent Treatment & Sleep

My Conditions

Continence & Menstruation

Communication

Discharge Plan & Appointments

Appointment Questions & Notes

Hospital Bag Suggestions & List

Crisis Plan & Helplines

About Me

NHS # .....

Date of Birth: .....

Full Name: .....

Name I like to be called: .....

The gender pronouns I use: .....

Ethnicity: ..... I speak: .....

Faith & Spiritual Needs .....

Address: .....

.....

.....

.....Postcode: .....

Home Tel: .....

Mobile: .....

Next of Kin name: .....

Tel: ..... They are my: .....

Permission to contact Next of Kin: Yes ☐ No ☐

Height ..... Weight .....

Vape ☐ Smoke ☐ (Per Week .....) Ex-Smoker ☐ Non-Smoker ☐

Drink Alcohol: No ☐ Yes ☐ (Units Per Week .....)

Non-Prescription Substances: No ☐ Yes ☐ Prefer Not to Say ☐

Advance Decision? (Attach) ☐

GP .....

Surgery Address .....

.....

Are your prescriptions free? ☐

I need help to communicate:

Yes ☐ No ☐ Sometimes ☐

(Please see page ..... for details)

Carers

At home, I need help with daily living: Yes ☐ No ☐

I receive care from: A Carer/PA ☐ Care Agency ☐ Spouse ☐

A Friend ☐ A Relative ☐ A Child ☐ Other .....

Name of Primary Carer: .....

Tel: ..... They are my: .....

Permission to contact Carer: Yes ☐ No ☐

They help me with: .....

.....

Care Agency (if applicable): .....

Tel: ..... Care Hours per week: .....

I have a Care Plan: Yes ☐ No ☐ (Please attach a copy)

Social Services # .....

Name of Social Worker: .....

Other professionals involved in my care include:

Name: ..... Specialty: .....

Hospital: ..... Tel: .....

Name: ..... Specialty: .....

Hospital: ..... Tel: .....

Name: ..... Specialty: .....

Hospital: ..... Tel: .....

Name: ..... Specialty: .....

Hospital: ..... Tel: .....

Medication

Current Medication.

Last updated: .....

Regular medication & supplements

Name, dose, how many times per day, form (tablet, liquid, IM, NG, etc)

As-required medication

Medical appliances, implants, stents, coils, drains, feeds, etc

Things I may find difficult, or need help with, to take medication

Swallowing ☐ Crushing Tablets ☐ Injections ☐ Feeds ☐

Inhalers/Nebulisers ☐ Other .....

Hospital Bag Checklist

List your inpatient essentials to help you or your family and carers remember what to pack.

☐ .....

☐ .....

☐ .....

☐ .....

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Hospital Bag Suggestions

A few ideas to help you design your own hospital bag checklist on the next page.

Don't forget!

- My Chronic Health & Care Passport with contact numbers in it.
- My Medication, and a list of what I take, including supplements.
- My Admission Letter or Documents (if asked to bring any).
- Samples (or anything else requested for a planned admission).
- Leave any unnecessary jewellery or valuables at home.

Everyday essentials

- Mobile Phone
- Charger
- Headphones
- Notepad & Pen
- Money (Very Small Amount)
- Glasses/Contacts & Case
- Dentures
- Tissues
- Keys (if nobody can bring them in)

Medical items

- Medication & List
- Mobility Aids
- Communication Aids
- Wheelchair Cushions etc
- Adapted Cutlery or Straws
- Continence Supplies (eg: Stoma Kit)
- Menstrual Products
- Supports/Straps/Braces
- TENS machine
- Heat Pad

Clothes & toiletries (travel-size toiletries can be handy here!)

- Day Clothes: loose, easy to put on if sore, weak, or post-op.
- Comfy Underwear
- Slippers: waterproof soles are very useful.
- Nightwear: no metal zips/buttons (for scans).
- Dressing Gown
- Toothbrush/Toothpaste
- Lipsalve
- Hairbrush/Comb/Bands
- Soap, Flannel, Towel, Deodorant
- Shampoo/Dry Shampoo
- Shaving Supplies, Small Mirror
- Hand Cream & Nail File

Entertainment & sleep

- Book, Magazine, Puzzles
- Audiobooks, Podcasts, Music, Netflix
- Colouring Book, Pens
- Eye Mask
- Earplugs
- Sweets/Snacks

History of anaphylaxis?

Yes ☐ No ☐

Allergies

Allergies to medication

Name of Medication	Type of Reaction

Allergies to food

Other allergies, intolerances, warnings, and allergy notes

Medical History

Medical History Summary.
Last updated: .....

I am able to work or study: Full Time ☐ Part Time ☐
Mainly From Home ☐ Not At All ☐ Other .....
I am: Able to go out regularly ☐ Mainly Housebound ☐
Mainly Bedbound ☐ Fully Housebound ☐ Fully Bedbound ☐

My main diagnoses (see individual conditions sheets for more detail)

Therapies used to manage my symptoms include (physio, CBT, etc)

Recent Admissions, Tests, Scans (more in 'Recent Treatment' section)

Date notes were taken: .....
Appointment/Reason for notes:
.....

Appointment Notes

Notes for/from my appointment

Contact info from my appointment / things to bring or ask next time

What to Ask at Appointments

Remember to take a list of all your current medication and supplements, if appropriate.

What do I want to achieve at this appointment?

.....

.....

The things I most need help with today include

Pain Management ☐ Medication ☐ Mobility ☐ Fatigue ☐

Nutrition ☐ Mental Health ☐ Care Needs ☐ Sleep ☐

A New Symptom ☐ An Acute Change ☐ Reassurance ☐

Advice on the Next Step ☐ Clarity About My Situation ☐

Referral to Another Specialist for Tests, Advice, or Surgery ☐

Other: .....

.....

Example questions. Underline what you want to ask, tick when done

What are the tests for? ☐ When/how will I get the results? ☐

What were my results? ☐ What do they mean? ☐

What does treatment involve? ☐ How long will it take? ☐

What can I do to help myself? ☐ What happens next? ☐

How long is the waiting list? ☐ What are the risks? ☐

When's my next appointment? ☐ How will you contact me? ☐

Who do I contact if things change or I am worried? ☐

Any other questions or concerns: .....

.....

.....

.....

Surgical History Summary.

Last updated: .....

Surgical History

Previous surgical procedures

Type of Surgery	Date of Surgery (approx)
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Other procedures or treatments

.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Anaesthetics - any problems or special instructions

.....

.....

I would accept a blood transfusion: Yes ☐ No ☐

Other: ..... Blood Group: .....

Organ Donation: Already Registered ☐ Agree to Opt-In ☐

I would like to Opt-Out of organ donation ☐

Ability Aids

These are the aids I use and how they help. (Tick all that apply)

- [ ] Wheelchair or Powerchair .....
- [ ] Crutches, Walking Stick .....
- [ ] Walker or Zimmer Frame .....
- [ ] White Cane .....
- [ ] Prosthetics .....
- [ ] Service Animal .....
- [ ] Glasses, Contact Lenses, Magnifier .....
- [ ] Hearing Aid or Implant .....
- [ ] Splints or Supports .....
- [ ] Compression Wear .....
- [ ] Grab-Rails and Perching Stools .....
- [ ] Earplugs or Ear Defenders .....
- [ ] Eye Mask or Dark Glasses .....
- [ ] Face mask or Respirator .....
- [ ] Oxygen. Inhaler, or Nebulizer .....
- [ ] Feed Pump or TPN .....
- [ ] Adapted Kitchen Utensils or Cups .....
- [ ] Dentures or Mouth Guards .....
- [ ] Bed Siderails, Air Mattress .....
- [ ] Hoists or Lifts .....
- [ ] Raised Toilet Seat, Frame, Bedpan .....
- [ ] Grab Sticks, Long-Handled Brush .....
- [ ] Assistive Tech or AAC .....
- [ ] Other .....

Date notes were taken: .....

Appointment/Reason for notes:

.....

Appointment Notes

Notes for/from my appointment

Contact info from my appointment / things to bring or ask next time

What to Ask at Appointments

Remember to take a list of all your current medication and supplements, if appropriate.

What do I want to achieve at this appointment?

.....

.....

The things I most need help with today include

Pain Management ☐ Medication ☐ Mobility ☐ Fatigue ☐

Nutrition ☐ Mental Health ☐ Care Needs ☐ Sleep ☐

A New Symptom ☐ An Acute Change ☐ Reassurance ☐

Advice on the Next Step ☐ Clarity About My Situation ☐

Referral to Another Specialist for Tests, Advice, or Surgery ☐

Other: .....

.....

Example questions. Tick all you want to ask.

What are the tests for? ☐ When/how will I get the results? ☐

What were my results? ☐ What do they mean? ☐

What does treatment involve? ☐ How long will it take? ☐

What can I do to help myself? ☐ What happens next? ☐

How long is the waiting list? ☐ What are the risks? ☐

When's my next appointment? ☐ How will you contact me? ☐

Who do I contact if things change or I am worried? ☐

Any other questions or concerns: .....

.....

.....

.....

Things I might need assistance with.
More about mobility on page .....
and communication on page .....

Assistance

Tick all that you need help with. X any you cannot manage <u>even with help</u>. Explain what you need (eg: cut up food, crush meds, bedbath, hoist). Leave blank if no assistance is required.

- ☐ Washing (Bedside) .....
- ☐ Bathing/Showering (Bathroom) .....
- ☐ Personal Care (Teeth, Hair, Shaving) .....
- ☐ Drinking .....
- ☐ Eating .....
- ☐ Dressing .....
- ☐ Taking Medication .....
- ☐ Turning in Bed .....
- ☐ Sleeping .....
- ☐ Toileting (Bedside) .....
- ☐ Accessing the Toilet (Bathroom) .....
- ☐ Changing Medical Appliances .....
- ☐ Getting Into/Out of Bed .....
- ☐ Having Blood Tests/Injections .....
- ☐ Having Scans .....
- ☐ Talking to Doctors .....
- ☐ Understanding Care Plans .....
- ☐ Reading Information .....
- ☐ Signing Consent Forms .....
- ☐ Soothing/Calming Myself .....
- ☐ Other .....

Dietary Requirements

Special Dietary Requirements. Tick all that apply.

Dietary requirements

Vegetarian ☐ Vegan ☐ Pescatarian ☐ Halal ☐
Kosher ☐ Gluten Free ☐ Dairy Free ☐ Soya Free ☐
Sugar Free ☐ Low GI ☐ Low Fat ☐ Low Carb ☐
Low Fibre ☐ Low Residue ☐ Low Fodmap ☐
Low Histamine ☐ High Protein ☐ High Calorie ☐
Low Sodium ☐ High Sodium ☐ Soft/Pureed ☐
Thickened Liquids ☐ Liquids Only ☐ Nil By Mouth ☐
Other ....

Supplementary/replacement nutrition and other needs

....
....
....
....

Food allergy/intolerance reminder (see Allergies page for more info)

....
....
....

Things I may find difficult, or need help to manage

Swallowing ☐ Cutting up Food ☐ Sitting Up ☐ Feeding Myself ☐
Cutlery ☐ Making Healthy Choices ☐ Motivation ☐ Nausea ☐
Red Tray ☐ Other ....

Appointments

Keep a handy note or ask your healthcare team to write your appointments here.

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Date: .... Time: .... Name: ....
Place: .... Department/Reason: ....

Discharge Plan

This is how you can help me prepare to go home.

Before I can return to where I live, I may need...

- ☐ A Discharge Planning Meeting .....
  This needs to involve: .....
- ☐ A Care Plan .....
- ☐ Carers in place at home .....
- ☐ A Physio Assessment .....
- ☐ An OT Assessment .....
- ☐ A Step-Climb / Stair Safety Test .....
- ☐ A Mental Health Assessment .....
- ☐ A Social Services Assessment .....
- ☐ Carer/Advocate to attend meetings/assessments with me

  .....

  Carer/Advocate Name: .....

  Contact: .....
- ☐ Other .....

  .....

  .....

  .....

  .....

Before discharging me, please contact

Name: .....

Contact: .....

Relationship to me: .....

To help with menu choices, tick the food & drinks you like.

Food Preferences

Food & Drink Preferences
(Examples from typical NHS Hospital Menus)

Tea ☐ Coffee ☐ Hot Chocolate ☐ Milk ☐ Water ☐

Bovril ☐ Cordial/Squash ☐ Apple Juice ☐ Orange Juice ☐

Sandwiches (White Bread) ☐ Sandwiches (Wholemeal) ☐

Vegetables ☐ Fish ☐ Chicken/Turkey ☐ Red Meat ☐

Spicy Food ☐ Pasta Dishes ☐ Sweet & Sour ☐

Roast Dinners ☐ Fish & Chips ☐ Jacket Potato ☐

Cottage Pie/Casserole ☐ Salads ☐ Omelette ☐

Cheese ☐ Beans ☐ Potatoes (Mash/Boiled/Roast) ☐

Icecream ☐ Puddings ☐ Custard ☐ Cake ☐ Fruit ☐

Jelly ☐ Yoghurt ☐ Biscuits ☐ Cheese & Crackers ☐

My Favourite Breakfast

.....

.....

My Favourite Lunch

.....

.....

My Favourite Dinner

.....

.....

Pain

The types of chronic pain I experience and how I cope.

When patients experience chronic pain it can be difficult to comprehend how bad it really is when using a traditional scale. Pain, and how we cope with it, is very individual but hopefully this will help you to understand mine.

How I rate my pain
(Please describe what the scale means to you. 1 = mildest, 10 = worst)

1) .....
2) .....
3) .....
4) .....
5) .....
6) .....
7) .....
8) .....
9) .....
10) .....

The types of chronic pain that I often experience include

.....
.....
.....

How I manage it at home

.....
.....
.....

How I need it managed in hospital

.....
.....

Help Communicating

The help I may need to communicate.

To help me communicate, I need

- ☐ Help from a Carer .....
- ☐ A Picture Book or Symbol Set .....
- ☐ Letter/Language Board .....
- ☐ AI Voice/AAC Technology .....
- ☐ Sign Language or Makaton .....
- ☐ To Lipread .....
- ☐ A Hearing Aid/Implant .....
- ☐ Large Print or Braille .....
- ☐ Simplified Written Information .....
- ☐ Information Read Aloud to Me .....
- ☐ Information Written Down .....
- ☐ Help Signing Consent Forms .....
- ☐ You to Speak Up .....
- ☐ You to Speak Softly .....
- ☐ You to Use Simple Language .....
- ☐ To Not Have Too Many People Talking .....
- ☐ To Have Important Things Repeated .....
- ☐ Information in this Language .....
- ☐ An Interpreter Who Speaks: .....
- ☐ Other .....

.....
.....

Communication

I sometimes have difficulty communicating: Yes ☐ No ☐

I sometimes have difficulty with...
(Tick all that apply, and explain more if you can)

- ☐ Speaking .....
- ☐ Hearing .....
- ☐ Vision .....
- ☐ Reading .....
- ☐ Writing .....
- ☐ Understanding Numbers .....
- ☐ Comprehension .....
- ☐ Memory .....
- ☐ Attention .....
- ☐ Thinking Clearly .....
- ☐ Finding the Right Words .....
- ☐ Difficulty with Multiple Speakers .....
- ☐ Becoming Overwhelmed .....
- ☐ Decision Paralysis .....
- ☐ Eye Contact .....
- ☐ Understanding Facial Expressions .....
- ☐ Recognising Faces .....
- ☐ Interpreting Jokes or Taking Things Literally .....
- ☐ Difficulty Understanding the Local Language .....
- ☐ Other .....

.....

.....

Mobility

How I move around and the help I may need to do so safely.
Falls risk? Yes ☐ No ☐

When moving around I can...
(Tick all that apply)

Move around independently <u>without</u> aids ☐
Move around independently <u>with</u> aids ☐
Move around with help from another person ☐
Stand for a few minutes ☐ Stand to transfer ☐
Walk a short distance ☐ Walk a few steps/indoors ☐
Climb a few steps ☐ Climb stairs ☐ Walk up a slope ☐
Sit upright in any chair ☐ Sit up in a supportive chair ☐
Sit reclined on a chair or sofa ☐ Sit propped up in bed ☐
Must remain relatively flat and in bed ☐
<u>Cannot</u> safely stand ☐ <u>Cannot</u> safely get out of bed ☐

The mobility aids I use include

Wheelchair (Full Time) ☐ Wheelchair (Ambulatory) ☐
Powerchair ☐ Scooter ☐ Walker/Rollator ☐
Zimmer/Hospital Frame ☐ Cane/Walking Stick ☐
Crutches ☐ Seat Riser/Recliner ☐ Strap/Splint/Brace ☐
Prosthetic (upper limb) ☐ Prosthetic (lower limb) ☐
Other: .....

What I would like you to know about my mobility

.....

.....

.....

Mental Health

Find details of my specific MH conditions on pages .....

I experience the following difficulties with my Mental Health

Anxiety ☐ Depression ☐ PTSD ☐ SAD ☐ OCD ☐
Dissociative Episodes ☐ Paranoia ☐ Mania ☐ Panic ☐
Hyperventilation ☐ Obsessive Worrying ☐ Catastrophising ☐
Disordered Eating ☐ Body Dysmorphia ☐ Self-Harm ☐
Skin-Picking ☐ Hallucinations ☐ Psychosis ☐ Addiction ☐
Alcoholism ☐ Overwhelm ☐ Aversion ☐ Delusions ☐
Hyperactivity ☐ Lethargy ☐ PMS/PMDD ☐ Phobias ☐
Agoraphobia ☐ Claustraphobia ☐ Social Anxiety ☐
Obsessive Thoughts ☐ Intrusive Thoughts ☐ Suicidal Ideation ☐
Other .....

.....

.....

.....

I am very uncomfortable being touched, treated, or examined by certain sexes/genders: Yes ☐ No ☐

(Please explain whose presence you would find distressing)

.....

.....

To feel at ease, I require a chaperone during 1-to-1 care, including
(Tick all that apply, and explain more if you need to)

Scans ☐ Blood Tests/Injections ☐ Procedures ☐ Physio ☐
Intimate Examinations ☐ All Examinations ☐ Washing ☐
Dressing ☐ Appointments ☐ Other .....

.....

I have a menstrual cycle:
Yes ☐ No ☐ Used to ☐

Menstruation

My cycle is: Regular ☐ Irregular ☐ Currently paused ☐

To manage my menstrual needs I require help with: .....

.....

.....

I use the following products for my menstrual health

Sanitary Pads ☐ Reusable Pads ☐ Tampons ☐ Cup ☐
Period Underwear ☐ HRT ☐ GnRH Agonist ☐ Pill ☐
Coil ☐ Implant ☐ Injections ☐ Patch ☐ Blockers ☐
Other .....

.....

These things help me with my pain

Stick-on Heat Pads ☐ Electric Heat Pads ☐ TENS ☐
Hot Water Bottle ☐ Hot Bath ☐ Acupuncture ☐ Yoga ☐
Meditation ☐ CBD Tampons ☐ Painkillers ☐
Other .....

When I am in a lot of pain or my mental health is suffering because of my menstrual cycle, the best way to help me is by:

.....

.....

Hysterectomy? (Full or Partial) ☐

I am under the care of a Consultant, Specialist Nurse, or clinic to oversee my genito-urinary health:
Name: .....
Contact: .....

Gender Affirmation Surgery? ☐

Continence

I need help to manage my toileting: Yes ☐ No ☐

I have: Intermittent Incontinence ☐ Bladder Incontinence ☐
Bowel Incontinence ☐ No problems with continence ☐

I have an: Ileostomy ☐ Colostomy ☐ J-Pouch ☐
Urostomy: Incontinent Diversion ☐ Continent Diversion ☐
SPC Catheter ☐ IUC Catheter ☐ Intermittent Catheter ☐

My stoma(s) are: Permanent ☐ Temporary ☐ Other .....
I've had my stoma(s) since .....
Preferred Ileostomy/Colostomy bags: Two-Piece ☐ Drainable ☐
Brand and size: .....
My preferred Urostomy bags are: Two-Piece ☐ Drainable ☐
Brand and size: .....
My SPC/IUC catheter was changed/inserted on .....
My catheter type is: Male Anatomy ☐ Female Anatomy ☐
Brand and size: .....

Please offer me help with: Changing or emptying my bag ☐
Inserting my catheter ☐ Enemas ☐ Suppositories ☐
Changing pads ☐ Cleanliness ☐ Other (see below) ☐

I require enemas, laxatives, or other intervention to manage my toileting needs. (Please give details) .....
.....
.....

Other ways I manage my toileting include: Continence Pads ☐
Mattress Protector ☐ Continence Underwear ☐
Other .....

Mental Health

More about my Mental Health and Emotional Wellbeing

At times, I harm myself / others by .....
.....
.....
.....
.....

I manage my symptoms by .....
.....
.....
.....
.....

Things I find triggering or distressing include .....
.....
.....
.....
.....

Things you can do to help me: .....
.....
.....
.....

My Mental Health care is overseen by: .....
Tel: ..... Hospital/Clinic.....

If I am in crisis please call: .....
Tel: ..... They are my: .....

Recent Treatment

If you've had any recent tests, admissions, or medications please add them in here.

Recent inpatient admissions or A&E visits (within the last 6 -12 months)
(Please add the date, hospital/clinic, and brief reason for admission)

Recent Tests, Scans, Procedures, or Day Surgery (& result if known)

Recently Prescribed Medication (eg: antibiotics, and date taken)

I sometimes struggle to sleep or need help to rest well.

Sleep

I have: A Sleep Disorder ☐ Sleep Apnea ☐ Narcolepsy ☐
Insomnia ☐ Nightmares ☐ Parasomnias ☐ RLS ☐
Fatigue ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐
Trouble Waking Up ☐ Other .....

I usually sleep: Too Much ☐ Enough ☐ Not Enough ☐
Other .....

My sleep is usually: Refreshing ☐ Unrefreshing ☐ Mixed ☐
Other .....

Things that help me sleep well include

Things that make sleeping difficult

To sleep safely & comfortably I need

Medication ☐ Bed Rails ☐ CPAP ☐ Air Mattress ☐
Sheet Protector ☐ Eye Mask ☐ Lights Off ☐ Quiet ☐
Other .....

My Conditions

More about my Chronic Illnesses and Disabilities.

Name of illness, disability, or difficulty

My main symptoms / how I am affected

How I manage these challenges

How you can help me

What I'd like you to know about my condition

Medical professional / team who usually help with this

Name:

Contact:

This person can explain more if I am unable to

Name & Relationship:

Telephone Number:

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