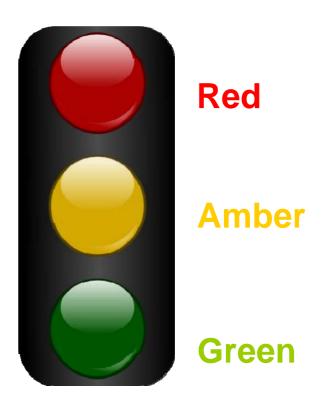
NHS Foundation Trust





HOSPITAL ASSESSMENTFor people with learning disabilities.

This assessment gives hospital staff important information about you.

Please take it with you if you have to go into hospital and give it to the people looking after you.

Please note: **Value judgments** about quality of life must be made in consultation with you, your family, carers and other professionals, following the principles of the mental capacity act (2005). This includes Resuscitation Status.

IT IS IMPORTANT ALL THE HOSPITAL STAFF WHO LOOK AFTER YOU READ THIS ASSESSMENT

Adapted from: Elliott K & Dean E (2006), Gloucestershire Partnership NHS Trust/



RED – ALERTThings you <u>must</u> know about me



Name: Likes to be known as: Address:	NHS No			
Postcode: Date of Birth:	Tel No:			
GP:	Address:			
Next of Kin:	Relationship:			
	Tel No:			
Key Worker/main carer:	Relationship			
	Tel No:			
Professionals Involved:	Tel No:			
Religion:	Religious requests:			
Allergies:				
Current medication, doses and times taken:				
Current medical conditions:				
Brief medical history:				
Level of communication/comprehension:				
Medical interventions – how to take my blood, give injections, take temperature, medication, BP etc				
Behaviors that may challenge or cause risk:				
Do you know if I have made a valid Advanced Directive	e? TES	S [] NO	
Do I have a lasting power of attorney for personal welfa Name: co	re? TYES	6 [] NO	
Heart (heart problems):	☐ YE	S [] NO	
Breathing (respiratory problems):	☐ YES	S [] NO	
Epilepsy:	☐ YES	S [] NO	
Gastric Disorders:	☐ YES	S [] NO	
Eating and Drinking issues:	☐ YES	S [] NO	

AMBER Things that are really important for me.

Completed by:	Date:
Communication: How to communicate with me.	
Information sharing: How to help me understand things.	
Seeing/hearing: Problems with sight or hearing	
Eating (swallowing): Food cut up, choking, help with feeding.	
Drinking (swallowing): Small amounts, Choking	
Going to toilet: Continence aids, help to get to toilet.	
Moving around: Posture in bed, walking aids.	
Pain: How you know I am in pain	
Sleeping: Sleep pattern, sleep routine	
Keeping safe: Bed rails, controlling behaviour, absconding	
Personal care: Dressing, washing etc.	
Level of support: Who needs to stay and how often.	

GREENMy Likes and dislikes.

Completed by:	Date:	Date:		
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. Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.				
Things I Like Please do this	Things I don't Like Don't do this			