

Hospital Information booklet for Acute Hospital Admission



This booklet is about my stay in hospital. It will help the staff to give me more individual care and give them more information about my needs.



If I need to, I can ask for help to fill in this booklet.
It should be completed as close as possible to my stay in hospital.



The information must be correct and up-to-date.



Name	
Date of birth	
CHI number	
Carefirst number	
Address	
Religion	
GP name	
GP address	
GP phone	
Other professional involved	
Carer's name	
Carer's address	
Carer's phone number	
Carer's mobile number	
Learning disability contact	
Care manager/social worker	
Named person (MHA)	

This booklet is about	
But it was filled in by	
Relationship	
Date	
Signature	

How I show you I am in distressed or in pain:

.....

I have attached a DisDAT

YES

NO

My health risks:

I have difficulty/need support with:		High	Moderate	Low
Eating				
Drinking				
Swallowing				
Mobility				
Toileting				
Epilepsy				

Please see relevant sections for more details

YES

NO

I have a visual impairment

I have glasses

I have a hearing impairment

I have a hearing aid

How I give my permission to my treatment

The communication information (page 5) shows you the best way to communicate with me. You should use this advice to:-

- Talk to me about my health problems
- To let me know the different choices I have to treat my problems
- To make sure I know what is going to happen to me
- To check I have remembered what you have told me
- To check I have not changed my mind before you give me any treatment or care.

I may be able to make up my mind about some things but not others.

I can make up my own mind about my own treatment Yes No

I need help to make up my mind e.g. pictures, symbols, signs Yes No

My Welfare Guardian is: *(if applicable)*

I need an interpreter to help me *(please tick which one)*

Spoken Language *(please state which one)* _____

Signing: BSL Signalong Makaton

Other: *(please state)* _____

These are the people that will help me make decisions about my care:

Name	Relation	Telephone number

If I am unable to make choices or consent to my treatment **SECTION 47 PART 5 Adults with Incapacity (Scotland) Act 2000** requires to be completed.

Communication

My first language is:

Other languages I understand are:

.....

.....

Understanding (comphrehension)

Please tick boxes

I usually understand what is being said:

You can help me by using:

- | | | | |
|-------------------------|--------------------------|---------------------|--------------------------|
| Short, simple questions | <input type="checkbox"/> | Photographs | <input type="checkbox"/> |
| Objects | <input type="checkbox"/> | Symbols | <input type="checkbox"/> |
| Pictures | <input type="checkbox"/> | Gestures | <input type="checkbox"/> |
| Signing | <input type="checkbox"/> | Please state which: | _____ |

Demonstrating (showing what you are talking about)

I communicate using: (please tick all relevant boxes)

- | | | | |
|----------------------|--------------------------|---|--------------------------|
| Speech | <input type="checkbox"/> | Gestures | <input type="checkbox"/> |
| Objects of reference | <input type="checkbox"/> | Signing | <input type="checkbox"/> |
| Photographs | <input type="checkbox"/> | Vocalisations | <input type="checkbox"/> |
| Symbols | | Facial expressions and
body language | <input type="checkbox"/> |
| Communication aid | <input type="checkbox"/> | Please state which: | _____ |

Medication

Please attach my repeat prescription sheet

I am allergic to this medication: _____

This is the medication I take:

Name of medication	Form- (<i>tablet or syrup</i>)	Dose	Time	How I like to take my medication (<i>e.g. with water, on a spoon or with thickened drink</i>)

This is the help I need to take my medication:

.....

.....

.....

The covert medication policy applies

Yes

No

Information About General Health:

If known, cause of my Learning Disability:

.....

.....

My specific health needs and illnesses are:

(i.e. epilepsy, diabetes etc)

.....

.....

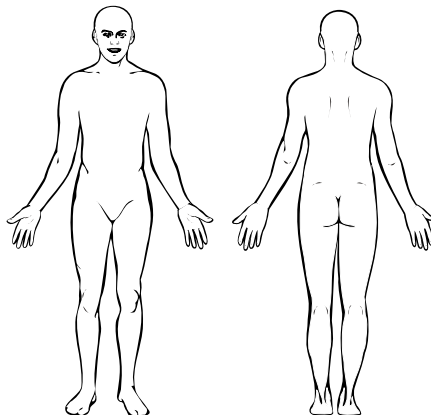
Things that I am at risk of: (Tick where appropriate)

- | | | | |
|----------------|--------------------------|---------------|--------------------------|
| Falls | <input type="checkbox"/> | Unsteady Gait | <input type="checkbox"/> |
| Wandering Off | <input type="checkbox"/> | Aspiration | <input type="checkbox"/> |
| Pressure Sores | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> |

Other : _____

Tissue Viability: (on admission to hospital)

- | | | |
|------------------------------------|--------------------------|---|
| My skin is intact upon admission | <input type="checkbox"/> | <input type="checkbox"/> There is current Concern relating to my skin |
| Previous history of skin breakdown | <input type="checkbox"/> | <input type="checkbox"/> I am using dressings at the moment |



Eating, drinking and swallowing

Foods I like	
Drinks I like	
Foods I don't like	
Drinks I don't like	
I use special cups, plates and cutlery (please list)	
I have difficulty chewing foods	
I have difficulty swallowing foods	
The texture of my food needs to be	
I have difficulty with liquids/drinks	
I have difficulty swallowing liquids/ drinks	
The texture of my drinks needs to be...	
I take nutrition supplements (please list what they are and how they are taken)	
I take no food or drink by mouth	
(please give details of feeding methods)	

I have attached my eating and drinking plans

YES

NO

Activities of daily living

This tells you the equipment and any help I need

Mobility

Eg: I use a walking frame, stick

Washing

Eg: Shower, bath

Oral hygiene

Dentures, tooth decay

Dressing

Eg: to put clothes on, buttons

Toileting

Eg: reminders to go, catheter, incontinence garments

Sleep routine

Eg: sleep system, turning

Arrangements for discharge:

(e.g. contact carer, arrange transport, have prescription ready)

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Additional Information:

(e.g. what will help me relax and reduce anxieties prior to admission and during my stay)

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