**Know My Care Needs**

If I am transferred to a hospital or another department please make sure “Know My Care Needs” sheet is handed over to the staff.

Photo of me

My name is:

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| --- |
| **Please tick one of the following:** |
| 1. I do consent to this information being shared
2. I do not have capacity to consent to this information being shared so my best interest decision meeting included (names)…………………………………………………..
3. I have a Lasting Power of Attorney/Court of Protection/Appointee\* for health and welfare or advocate (name) ……………………………………………………………………
 |
| Date completed | By Whom |
| Relationship to person | How I was involved |
| Signature ………………………………………………………………………………………………….. |

\*Delete as appropriate

|  |  |
| --- | --- |
| Things you must know about me | C:\Users\jcollings\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\traffic-lights-4195506.jpg |
| **I like to be called:**  | **Allergies:** |
| Date of birth: |
| NHS Number: |
| Telephone/Mobile number(s): |
| **Person to contact in an emergency:** | **GP details:** |
| Relationship: |  |
| Contact details: |  |
| **Main Carer:**Contact details: |
| **My religion:** |  |
| My religious needs: |
|  |
| **How I communicate:** |
|  |
|  |
| **How do I tell you if I am in pain?** |
| **How to take my blood pressure:****How to take my blood:****How to give me injections:** |
| **How I take my medication:** |
| **Current medication: See attached Medication Administration Record (MAR) sheet for current medications or repeat prescription request form. If not attached please ask for a copy** |
| **Medical history:** |
| **I have got a ‘Last Wishes / End of Life Plan’ Yes No****I have got a Do Not Attempt Resuscitation Form Yes No****I have got a Health Passport Yes No****If not attached please ask for a copy** |

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| **Things that are important to me** | C:\Users\jcollings\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\traffic-lights-4195506.jpg |
| **What I do if I am not happy:**  |
| **My sight and hearing:****My mobility:****How I use the toilet:** |
| **How I eat: (Please include choking risks)****How I drink:** |

|  |  |
| --- | --- |
| **My likes and dislikes** | C:\Users\jcollings\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\traffic-lights-4195506.jpg |
| **What I like:****What I don’t like:** |

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| --- |
| **Guidance notes to help you complete this form:** |
| **I do consent to this information being shared:** Only tick this box if the person the form is about understands and is happy to share this information with any health and social care professionals involved in the care.**I do not have capacity to consent to this information being shared:** Please tick the box if you do not have capacity to consent and insert details of Lasting Power of Attorney (LPA), advocate or names involved in best interest decision as appropriate.**NHS Number:** Everyone is given an NHS number. If you don’t know what yours is ask your carer or GP?**Person to contact:** This may be your next of kin or the person that you would like to be contacted in the case of an emergency.**My religious needs**: Please include any special requirements about religious or spiritual needs recognising that staff may not be aware of all needs associated with every religion. Be as specific as you can.**How I communicate:** How do you usually communicate, e.g. verbally, using gestures, pointing or a mixture of both? Is literacy an issue? Does writing things down help?**How do I tell you if I am in pain:** How do you indicate pain or discomfort? Include anything that may help staff identify your needs.**How to take my blood pressure:/take my blood:/give injections:** Please insert any information that you are aware of which may enable the staff to support you better e.g. preferred environment, any sedation previously used (and information related to DoLS in place in the home).**How I take my medication:** Do you prefer medication in pill/tablet or liquid form? Do you prefer to take your medication in private? **Current medication:** If you don’t have a copy of your Medication Administration Record (MAR) sheet, or repeat prescription request form please ask your carer for it.**Medical history:** Please include all pertinent medical history including disabilities, diagnoses of long term mental and physical health conditions. | **I have got a Last Wishes /End of Life Plan / Do not attempt resuscitation form / Health passport:** These documents are usually discussed with you and your family and given to you following that discussion. Please keep a copy with this document so that your wishes can be communicated and respected.**What I do if I am not happy:** This relates to any behaviour or demonstration that indicates you are distressed or frightened. Please give as much information as possible to enable staff to support you better.**My sight and hearing:** do you need a hearing aid or glasses?**My mobility:** Do you need a walking aid? Are you prone to falls? Is your mobility affected by surfaces? Can you stand unaided from a sitting position? Do you need a special chair or cushion, or do your feet need raising to make you comfortable?**How I use the toilet**: Include details of assistance required and what is normal for you, including if you have a stoma and or urinary catheter.**How I eat and drink :** List any special dietary requirements. Do you need assistance to eat or drink e.g. does food need to be cut? Do you need adapted cutlery or crockery? Do you wear dentures? If you have swallowing difficulties do you require thickened fluids? What texture of food is required to help – soft or liquidised?**What I like and don’t like:** Include details about significant events in your past, favourite people, places or things that you particularly like or dislike.Developed by Quality in Care Team – Oct 14 |