

This document is to help people with learning disabilities and their support network to prepare for their annual health check.



It needs to be completed by the person, with support from people who know them well if required, before going to the annual health check appointment.

Please fill this book in and bring it back to the GP surgery



My name is:

.....  
I prefer to be called:

.....  
My pronouns are:

.....



Date of birth:

.....



Who is important to me?

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



Address: .....

.....

.....

.....

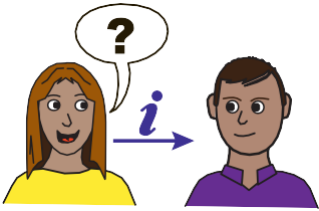
.....Telephone .....



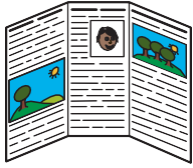
How do I want my GP practice to contact me?

.....

## Consent for Summary Care Record and additional information



Your doctor or nurse will have your basic summary care record. It has information about your health, the medications which you take and any medications which might make you ill (allergic reaction).



A doctor or nurse who doesn't know you very well, might ask to look at your Summary Care Record, this gives them the right information to care for you.



Only people like a doctor or nurse who are treating you can see your summary care record.

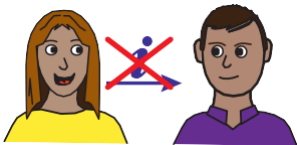
The doctor or nurse can add extra information to your record with things like a history of your health problems, operations, or an illness you've had. It can include information about who supports you and what help or type of information you might need at appointments.



The extra information can help doctors and nurses, no matter where you are treated, look after you and help keep you well.



If you would like extra information adding to your summary care record about your health and what support you need, let your doctor or nurse know.



If you don't want your information on your summary care record you can ask your doctor to remove it.



I consent for electronic record sharing including my summary care record.

I consent to share data with another professional (specified third party).

If the person does not have capacity, is it in their best interests to share information with

yes

no



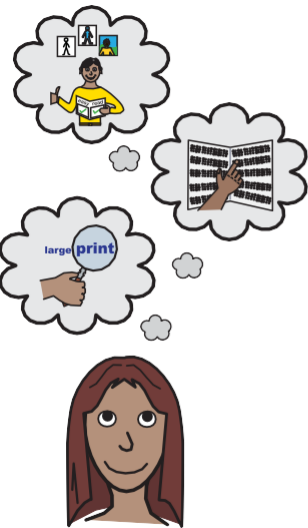

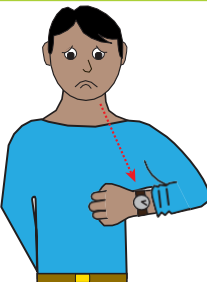


☐
☐
☐
☐
☐
☐





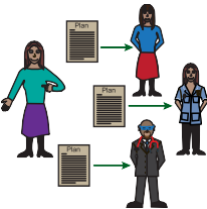

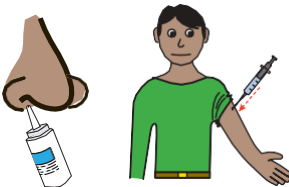
## The Equality Act (2010) - Reasonable Adjustments Alert



A reasonable adjustment is a small change any health staff can put in place, to make your Annual Health Check easier for you. Below are examples of reasonable adjustments.

You can get help to write down what you need in the blank section at the end of this document. You can ask for these reasonable adjustments to be available for you at your annual health check.

Reasonable Adjustment	How you can help me	Yes 	No 	Comments
	I need easy read documents.	<input type="checkbox"/>	<input type="checkbox"/>	
	I need information in large print.	<input type="checkbox"/>	<input type="checkbox"/>	
	I need information in another language – if so what language?	<input type="checkbox"/>	<input type="checkbox"/>	
	Other ways I need information sharing	<input type="checkbox"/>	<input type="checkbox"/>	
	I use a wheelchair and will need a hoist if I need a physical examination. I may need a home visit in this instance.	<input type="checkbox"/>	<input type="checkbox"/>	
	I find it difficult to wait in the doctors for my appointment, as it may make me anxious. I may need to wait outside until you are ready to see me.	<input type="checkbox"/>	<input type="checkbox"/>	
	I get very nervous at appointments and need my carer to help me understand what is happening.	<input type="checkbox"/>	<input type="checkbox"/>	

Reasonable Adjustment	How you can help me	Yes ✓	No ✗	Comments
	I may need to visit the surgery before my appointment to feel comfortable in the environment.	<input type="checkbox"/>	<input type="checkbox"/>	
	I need a longer appointment.	<input type="checkbox"/>	<input type="checkbox"/>	
	I need time to process information and answer questions.	<input type="checkbox"/>	<input type="checkbox"/>	
	Bright lights or loud noises may affect me.	<input type="checkbox"/>	<input type="checkbox"/>	
	My carer will support you to understand my needs.	<input type="checkbox"/>	<input type="checkbox"/>	
	Please also alert my carer of any appointments.	<input type="checkbox"/>	<input type="checkbox"/>	
	Other reasonable adjustments – please discuss			
	<b>Flu</b>	Yes ✓	No ✗	<b>Comments</b>
	Have you had your nasal spray or flu vaccine injection?	<input type="checkbox"/>	<input type="checkbox"/>	

Flu vaccines are usually given in autumn - you may also need other vaccinations like pneumonia.

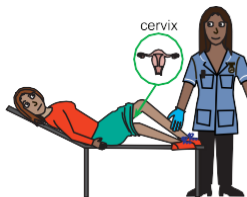
4 You may also need your HPV vaccine – please ask health care staff if you need these.



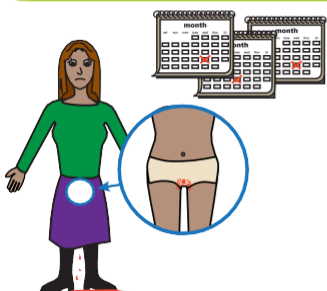
## Health screening - women

Yes ☒ No ☒

Comments



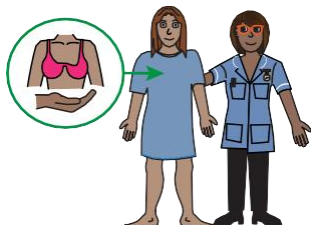
Have you had a smear test (cervical screening)? It helps spot early signs of cancer. If not, why not?

☐ ☐

Change in periods e.g. heavy bleeding in between periods, painful periods, or vaginal discharge

☐ ☐

If there is a problem then please bring your menstrual chart with you if you have one.



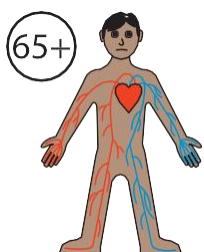
If you are over 50 have you had breast screening? If not, why not?

☐ ☐

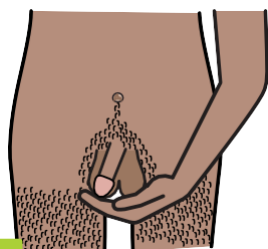
## Health screening - men

Yes ☒ No ☒

Comments



Have you had your Abdominal Aortic Aneurysm or AAA Screening? (Only men aged 65 plus)

☐ ☐

Do you check your own testicles / balls

☐ ☐

Have you felt/noticed any changes to your testicles / balls?

☐ ☐



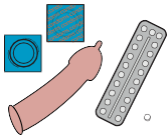
## Sexual health

Yes ☒ No ☒

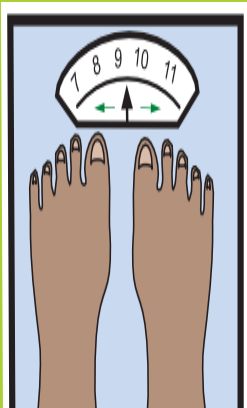
Comments



Are you sexually active?

☐☐

Do you use any  
contraception?  
If so, what ?

☐☐

## Weight

Yes ☒ No ☒

Comments

Has your weight changed in the last 3 – 6 months?

☐☐

Do you need specialist equipment to weigh you?

☐☐



## Dentist

Yes



No



## Comments

Do you have a dentist?  
When was your last visit?

☐☐

Do your teeth hurt?

☐☐

Do your gums bleed?

☐☐

Do you have a swelling or a lump?

☐☐

Do you have difficulty eating?

☐☐

## Eyes

Yes



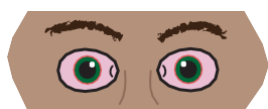
No



## Comments



When did you last have  
your eyes tested?

☐☐

Do you have any eyesight  
problems or wear  
glasses?

☐☐

## Hearing

Yes



No



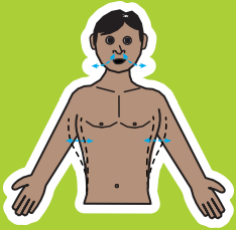
## Comments

Have you noticed any problems or  
changes to your hearing?

☐☐

Have you visited a hearing clinic  
(audiologist)?

☐☐



## Breathing

Yes ☒ No ☒

## Comments

Do you have coughing that won't go away (more than 3 weeks)?

☐ ☐


Any chest infections (hospital admissions in last 12 months for these)?

☐ ☐


Do you use Keeping My Chest Healthy  
[Keeping my chest healthy – Bradford District Care NHS Foundation Trust \(bdct.nhs.uk\)](http://www.bdct.nhs.uk)

☐ ☐


Are you coughing up blood?

☐ ☐


Is your spit an unusual colour?

☐ ☐


Do you have hay fever, allergies, asthma or chronic obstructive pulmonary disease?

☐ ☐


Are you breathless or wheezy?

☐ ☐


Do you smoke?

☐ ☐



## Eating and drinking

Yes ☒ No ☒

## Comments

Do you have a healthy diet with some fruit & veg? Do you have about 8 drinks a day?

☐ ☐


Does eating make you feel sick or unwell?

☐ ☐


Food allergies/intolerances?

☐ ☐


Do you have any changes to your appetite / hunger?

☐ ☐


Do you eat things that are not food?

☐ ☐


Do you have a PEG feed  
If so, do you see the dietician

☐ ☐


Do you have any coughing when eating or drinking or difficulty swallowing?

☐ ☐


Do you use any supplements like multi vitamins, fish oils, etc.?

☐ ☐





## Bowels

Yes



No



## Comments

Constipation – hard poo or can't go to the toilet?

☐
☐


Diarrhoea– watery poo and going too much

☐
☐


Bleeding from your bottom?

☐
☐


Difficulty getting to the toilet on time?

☐
☐


Have there been any changes to your poo?

☐
☐


Do you have a stoma ?

☐
☐


Are you aged 50-74? Have you received your bowel screening kit?

☐
☐




## Urine

Yes



No



## Comments

Pain when you wee?

☐
☐


Urine infection?

☐
☐


Wee more often?

☐
☐


Do you find it difficult to start weeing?

☐
☐


Does your wee start and stop when you are weeing?

☐
☐


Blood in your wee?

☐
☐


Difficulty in getting to the toilet in time?

☐
☐



## Breasts

Yes



No



## Comments

Do you check your breast for any changes?

☐
☐


Any lumps in breasts or armpits?

☐
☐


Any changes in the shape of your breasts?

☐
☐


Any changes to the skin on your breasts?

☐
☐


Any changes to shape of your nipples?

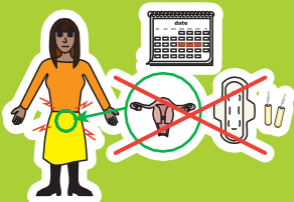
☐
☐


Do you have a change in colour to your breasts or nipples?

☐
☐


Any liquid from your nipple?

☐
☐

## Menopausal symptoms

Yes



No



## Comments

Do you feel tired?

☐
☐


Do you have mood swings?

☐
☐


Do you feel sad?

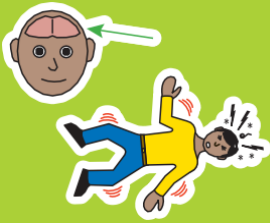
☐
☐


Do you feel irritable?

☐
☐


Do you have hot flushes?

☐
☐



## Brain

Yes No



## Comments

Do you have epilepsy?

☐
☐


How many seizures per month?

☐
☐


Any changes to seizures?

☐
☐


Are you under the care of an epilepsy specialist (neurologist)?

☐
☐


Do you have a regular review & when did you last see them?

☐
☐


Any triggers for epilepsy e.g. lights, TV, tired, temperature, infections?

☐
☐


Do you take your epilepsy medication regularly and as prescribed?

☐
☐


Do you have any side effects i.e. dizzy, sick, vision issues or feeling irritable?

☐
☐


**Have you had any of the following:**

Stroke

☐
☐


Fainting

☐
☐


Blackouts

☐
☐

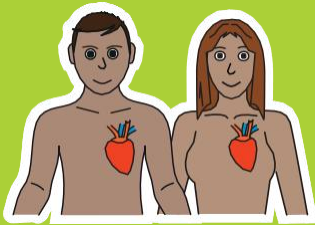

Pins and needles

☐
☐


Arm or leg weakness

☐
☐


**Please bring your seizure chart with you, if you have one.**



## Heart

Yes ☒ No ☒

## Comments

Difficulty or noisy breathing during the day and at night?

☐ ☐

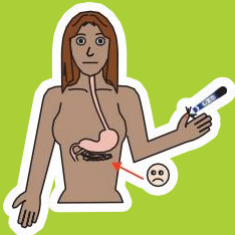
Chest pain when exercising?

☐ ☐

Do you need a regular ECG (depends on your medications or heart conditions)?

☐ ☐

Any swelling to the ankles, hands or body?

☐ ☐

## Diabetes

Yes ☒ No ☒

## Comments

Do you test your blood sugar regularly?  
Bring your blood sugar charts with you.

☐ ☐

Do you have any problems with your eyesight?

☐ ☐

Have you been for your diabetic annual review, eye screening & foot checks ?

☐ ☐

Have you been told you are pre diabetic?

☐ ☐

Do you need any help with your diabetes?



## Pain

Yes ☒ No ☒

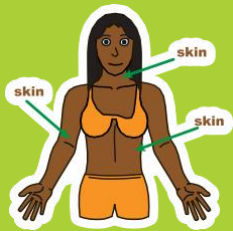
## Comments

How do you tell people if you have pain?

☐ ☐

Do you have pain and if so, do you have pain relief medicine to help?

☐ ☐



## Skin

Yes



No



## Comments

Dry or itchy skin

☐
☐


Prescribed skin cream

☐
☐


Warts

☐
☐


Cold sores

☐
☐


Sores or open wounds

☐
☐


Pressure area concerns

☐
☐



## Mental health

Yes



No



## Comments

Any worries about your memory or confusion?

☐
☐


Are you low, sad, unhappy or feel like crying?

☐
☐


Are you worried, frightened or anxious?

☐
☐


Do you feel like you can't cope or look after yourself?

☐
☐


Do you feel irritable, aggressive or violent?

☐
☐


Have you thought about harming yourself or actually harmed yourself?

☐
☐


Do you hear voices or see things?

☐
☐


Do you have any problem sleeping ?

☐
☐


Have you spoken to someone about how you feel?

☐
☐


Do you feel you need help with these things ?

☐
☐



## Feet

Yes



No



## Comments

Have you been to a podiatrist (foot specialist)? When did you last go?

☐
☐


If no, who cuts your nails?

☐
☐


Do you have any pain in your feet?

☐
☐


## Equipment

Do you have any equipment at home such as :

CPAP machine, hoist and slings, wheelchair, profiling bed, cough assist, etc.

Are these reviewed regularly ?

## Medication



Your doctor or pharmacist will talk to you about your medication and look at whether your medication is right for you. This should happen every year.



Do you have any problems taking your medication? Does this need to be liquid for you ?

Please write your medication here (or take your medication list):

## VIP hospital passport

This VIP Passport gives the hospital staff important information about you. Please take it with you if you need to go into hospital. Keep it next to you at all times. If you need help to fill it in ask a member of your family, a friend, a member of staff, your GP or nurse.

**About me**

My name: .....

I like to be called: .....

My religious needs are: .....

My ethnic background is: .....

Language I speak: .....

Language my carer speaks: .....

Things I don't like to do and eat: .....

Things I don't like to do and eat: .....

Other details included with me: .....

Other details included with me: .....

## Hospital Passport

[VIP-hospital-passport-1.docx](#)

Yes



No



## Comments

Do you have a Hospital Passport?  
This helps hospital staff understand how to help you - you need to keep it up to date.

☐
☐

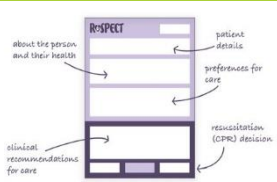


## Palliative care

Yes ☒ No ☒

Comments

Are you receiving support from palliative care services like the district nurses, a hospice or Marie Curie Nurse?

☐ ☐

## ReSPECT or DNAR CPR

Yes ☒ No ☒

Comments

Do you have a ReSPECT document or a 'DNAR' (Do Not Attempt Resuscitation). Any concerns or questions about these documents?

☐ ☐

## Bring a helper



You can ask questions at your health check.

You can bring someone with you who can help you in the appointment. You can decide if they will stay with you for some or all of the appointment.

## Do you have any questions?



At the end of your Annual Health Check, you should receive a copy of your Health Action Plan.


This helps you think about what you need to do to stay healthy over the next year. It also helps your support network know how to help you.




If you want one, please ask for it if it is not offered. It looks like this:

**NHS**

Staying healthy

**Annual Health Check Action Plan**  
 ..... Surgery

	<b>Patient Name:</b> ..... <b>Who supported me today:</b> ..... <b>Date of Annual Health Check:</b> ..... <b>Who completed check:</b> .....
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	Tick where needed:	Further Action Required: <small>Turn to page</small>
<div style="text-align: center; margin-bottom: 10px;">  </div> <p>We found you are in good health. You require no further treatment.</p>		
<div style="text-align: center; margin-bottom: 10px;">  </div> <p>Your next Annual Health Check will be on:</p>		<div style="text-align: center; margin-bottom: 10px;">  </div> <p>Date:.....</p>



Thank you for completing this form.

Please bring it with you to the health check appointment along with any other important documents about your health.