**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 your bed. 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/s I speak: ............................ Understand: ....................................  Language/s my carer speaks:....................... Understands:............................ | |
|  | Things I like to do and talk about: | Things I don’t like to do and talk about: |

|  |  |
| --- | --- |
|  | **Other services involved with me:** *(social services, other health services, other)* |

Date .............................................. Review date ............................................

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|  |  |
| --- | --- |
|  | **If I need emergency treatment you should know**: (*health or medical conditions, ReSPECT form if appropriate)* |
|  | **I am scared of needles**: Yes No **How you can help me:** |
|  | **I am allergic or sensitive to:** **How you can help me:** |
|  | **How best to give medical interventions**: *(eg reasonable adjustments for taking my blood, giving injections, take blood pressure, take an X-ray, other)* |
|  | **Any heart or breathing difficulties?** |
|  | **How I take medication:** *(eg crushed, injected, syrup, with food, other)*  **Please bring a supply & list of most recent medication** |
|  | **Operations or illnesses I have had:** |

# How I communicate

|  |  |
| --- | --- |
|  | **To help me understand what is happening and what treatment I need please use:** *(easy words, photos, signs, pictures, objects, video, other)* |
|  | **I communicate by**: *(speaking, signing, pictures, objects, facial expression, behaviour, other)* |

|  |  |
| --- | --- |
|  | **If I seem worried, angry, or upset, I may:** **You can help me with this by:** |
|  | **I will let you know I am in pain by**: (*telling you, pointing, being noisy or quiet, crying, self-harming, other)* |

|  |  |
| --- | --- |
|  | **About my hearing:** *(I have a good or not so good side, I am sensitive to noise, I need to see your lips when you speak to me, other)* |
|  | **About my sight:** *(I have a better side for you to approach me from, I wear glasses, lenses, certain lights bother me, other)* |

**Eating and drinking**

|  |  |
| --- | --- |
|  | **How I eat:** *(food liquidised, mashed, cut small, cooled, support needed, special equipment needed, risk of choking, other)*  **If I have special feeds, I will take some into hospital with me**  ....................................................................................................................  Foods I like: .................................................................................................  Foods I don’t like: ........................................................................................  Special diet: .................................................................................................  Risk of choking when eating, drinking, and swallowing:  .................................................................................................................... |
|  | **How I drink:** *(small amounts, thickened, special cup, cooled, other)*  ....................................................................................................................  Drinks I like: ................................................................................................  Drinks I don’t like:........................................................................................ |

|  |  |
| --- | --- |
|  | **How to help with my personal care:** *(washing, bathing, dressing, other)* |
|  | **How to support me at the toilet:** *(show where, help to get to, help at the toilet, stay with, fully assist, hoisting equipment, continence aids, other)* |
|  | **How to help me moving around:** *(posture, positioning in bed, turning,*  *walking aids, use of steps or lifts, hoisting equipment, other)* |
|  | **To help keep me safe:** *(bed rails, supervision needed, someone with me at night, vulnerability, other)* |

**Leaving hospital**

|  |  |
| --- | --- |
|  | **What people need to do before I leave hospital:** |
|  | **When planning for me to go home you need to talk to:** |
|  | If I need support after I leave hospital the Community Learning Disability Team may be able to help. Contact them on  .................................................................................................................... |
|  | I will need help to get home from hospital: Yes No |