Neurological Information Passport

Section One

Personal Information

TVDNY Neurological Alliance
Acklam Green Centre,
Stainsby Road,
Middlesbrough TS5 4JS
T: 01642 641825
E: admin@na-tvdny.org.uk
www.na-tvdny.org.uk

Registered Charity No: 1119043

Tees Valley, Durham and North Yorkshire
Neurological Alliance

How to use this Health Passport

Take this record with you whenever you visit:

- Your general practitioner (GP)
- Your hospital consultant
- Your specialist nurse
- Your occupational therapist
- Your physiotherapist
- Your continence adviser
- Your psychologist
- The accident and emergency department
- If you are admitted to hospital
- Go on holiday

Reminders

When you attend any clinic at the hospital or GP's surgery please bring:

- Your hospital /clinic appointment letter
- Any medication you may be taking
- This booklet

Confidentiality There is a risk to this information. This document carries personal information and you should take every precaution to ensure it is kept safely. Only give permission for the content to be seen by someone who knows how to respect confidential information

My Personal Information

This page gives hospital staff important information about you. Please take it with you when you go into hospital, and ask the clinical staff to read and use the information to help with discharge planning.

Title & Family Name	
First Name	
Date of Birth	
Hospital Number	
NHS Number	
Address	
Post Code	
Home Number	
Mobile Number	
E-Mail	
My Language is	
Caregiver Phone	
Caregiver Address	

Other Health Information

Doctor (GP) Address Telephone Number	
Physiotherapist	
Speech Therapist	
Social Worker	
Continence Advisor	
Podiatrist	
Psychologist	
Consultant	
Specialist Nurse	
Dentist	
Neurologist	
Hospital 1 James Cook	
Hospital 2 North Tees	
Occupational Therapist	

My Support Network

My main Caregiver is:	
Also involved in my care:	
My next of kin is:	
My advocate is:	
Making decisions for me: (please tick)	
I have a living will	☐
I have made Advanced Decisions	☐
I am a registered donor	☐
I have signed over power of Attorney	☐

My Medication

Please write down all medication prescribed and non-prescribed that you are taking

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

My Medication (continued)

Please write down all medication prescribed and non-prescribed that you are taking

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Medication Name:			
Time Taken	Dose	Start Date	Stop Date

Further Information

Intolerance or Allergies:

Any Other Information about Medication:

Personal Notes

Personal Notes

5 things to remember:

- Always ask questions
- Ask for copies of letters
- Check what happens next
- Record any changes to remind you to tell someone
- Attend appointments
  If an appointment is not suitable for you, telephone and change it

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Section Two

Condition Status

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My Neurological Condition is:

My symptoms started in:	

My main symptoms are these:

My Health:

About my other health conditions:

Things I notice:

How My Condition Affects Me:

Mobility:

I'm unable to walk	☐
I use a stick/frame	☐
I use a wheelchair	☐
I need a hoist to move me	☐
I'm unable to move in bed	☐
I get very tired	☐
I sometimes lose my balance	☐
I cannot write very well	☐

Dexterity:

I have finger spasms	☐
I do not grip things very well	☐
I cannot hold things for very long	☐
My hands are very painful	☐

How My Condition Affects Me:

Communication:

I'm unable to speak	☐
I have throat spasms	☐
I have special equipment to help me speak	☐
My eyesight is poor	☐
I have hearing loss	☐
I was born deaf	☐
I use British sign language	☐
I am deaf and do not read very well	☐
I have difficulty recalling information	☐
I forget things easily	☐

How My Condition Affects Me:

Personal care:

I have continence problems so may need to get to the toilet quickly	☐
I self-catheterise	☐
I wear a urinary catheter	☐
I wear a sheath and bag	☐
I suffer from constipation	☐
I suffer from diarrhoea	☐
I need help to wash and bathe	☐
I need help with cleaning my teeth	☐
I need help with buttons	☐
I need help with zips	☐
I need help putting on my shoes	☐
Heat and cold affect me	☐
I cannot function when I am cold	☐

How My Condition Affects Me:

Eating and drinking:

I need help to get a drink	☐
I need help to eat	☐
I have difficulty swallowing	☐
I am unable to eat solid food	☐
I have a PEG feeding tube	☐
I can eat and drink independently	☐
I need to eat with medication	☐

Nutrition:

I'm allergic to:	
I need a gluten-free diet	☐
I cannot have cow's milk	☐
I am vegetarian	☐

How My Condition Affects Me:

Equipment I need to use;

Item	
Hoist or a sling	☐
A walking stick	☐
A walking frame	☐
An adapted drinking cup	☐
A Tens machine	☐
Specialist cutlery	☐
A hearing aid	☐
A bed cradle	☐
A sleep alarm	☐
Lightwriter	☐
Raised toilet seat	☐
An inhaler	☐
Bath transfer	☐

My daily routine is:

Before discharge, I may need:

Record of people who have read this:

Date	Name