

Emergency details



My full name

.....



My birth date

.....

(Day/Month/Year)



Important health details

.....

.....

.....



Name of my main carer or
emergency contact person

.....



This person is my

.....

(mum, dad, support worker, other)



Their phone number

.....

Easy read

My hospital passport



This information helps hospital staff to understand my needs and care for me.

It is important to keep the information up to date.

About me



I like to be called

.....



485 777 3456

My NHS number

.....



My GP's name

.....



GP surgery's address

.....

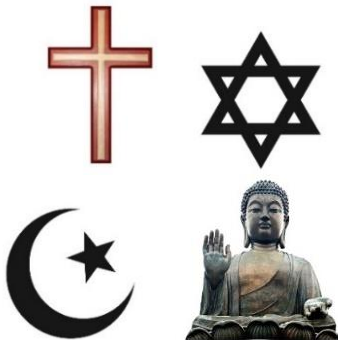
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GP surgery's phone number

.....



My religion or belief, if any

.....

My health



My health conditions

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.....

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.....

.....



I am allergic to

.....

.....

(medicines, foods, products, other)

My mental health



Things that make me feel
unhappy or worried

.....

.....

.....

(needles, loud noises, crowds, bright
lights, strong smells, being touched,
enclosed spaces, other)



How to help me feel better
if I am unhappy or worried

.....

.....

.....

(tell me to take deep breaths, take
me to a quiet place, explain what is
happening, talk to me gently, other)

How I communicate



I like to speak this language

.....



I wear glasses or contact lenses.

Please tick your answer:



Yes



No



I have a hearing aid.

Please tick your answer:



Yes



No



I use a communication aid.

Please tick your answer:



Yes



No

Hobbies or interests to talk to me about if I feel stressed



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.....

.....

How best to communicate with me



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.....
(use pictures, symbols or simple words, ask specific questions, give me time to answer, ask my carer to explain things to me, other)



How I might show that I am in pain

.....

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.....

.....

(rub my body, make a noise, rock in a chair, cry, become quiet and withdrawn, get angry, shout, other)

Moving around



I use a wheelchair.

Please tick your answer:

☐

Yes

☐

No



I use a walking or Zimmer frame.

Please tick your answer:

☐

Yes

☐

No



Any help that I need to
move around and stay safe

.....

.....

.....

.....

.....

(help to get out of bed or walk to
the bathroom, need bed rails, other)

My everyday needs



Any help that I need with my
personal care

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(help with washing, brushing teeth,
getting dressed, eating meals, other)

How I use the toilet



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(need help to get to the toilet, use a special chair, pads or catheter, other)

My sleep routine



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(usual times for going to bed and waking up, any help needed during the night, other)

Other important things to know about me



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(any important routines, likes, dislikes, other needs or ways to help me)



Date I filled in or updated this information

.....

(Day/Month/Year)