Hospital Passport

Name:

For more information about spina bifida and/or hydrocephalus, contact Shine: 01733 555988 • firstcontact@shinecharity.org.uk www.shinecharity.org.uk



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	General	Information	
First Name:			
Last Name:			
Would like to	be called:		
NHS Number:	:		
DOB:			
Address:			
Address line 2	2:		
Town:		Post code:	
Telephone No).:	Mobile No.:	
Email:			

Next of kin:

DNR in place	Yes	No 🗖	
Date completed:			
Power of Attorney Details:	/:		
Deprivation Of Lib	erty orders:		No
Religion (if any):	berty orders.		
GP Name:			
GP Address:			
Address line 2:			
Post code:		Telephone:	

Health Conditions/Diagnosis

Condition/Diagnosis 1:

Condition/Diagnosis 2:

Condition/Diagnosis 3:

Condition/Diagnosis 4:

Mitrofanoff-ACE: Yes		No	
If Yes, is bladder neck closed surgically:	Yes 🗌		No

Details:

Dotanoi			

Health Information			
Allergies:	Yes	Νο	
If YES please specify			
Current Medication			

Current Medication:

Medication name	Dose	Frequency

Additional information

Medication name	Dose	Frequency

Additional information

Health Information (continued)

Current Medication:



Additional information

Medication name	Dose	Frequency

Additional information

Medication name	Dose	Frequency	

Medication name	Dose	Frequency

Additional information

Medical History

Neurosurgery:

Neurology:

Orthopaedics/spinal:

Urology:

Colorectal:

Respiratory:

If yes, please provide more information			
Hydrocephalus inform	nation		
Shunt:	Yes	No	
Туре:			
Programmable:	Yes 🗌	No	
ETV	Yes 🗌	No	
Mobility information			
Stands to transfer:	Yes 🗌	No	
Uses a hoist:	Yes 🗌	No	
Uses a sliding board or other to transfer:	Yes 🗌	No	
Mobility Aids:			

Adverse reaction to anaesthetic: Yes

Νο

Pressure Area Care

Risk factors (please tick all that apply)

Reduced sensation in:

Feet

Legs

Buttocks

Reduced mobility

Under/overweight	
Bladder leakage	
Bowel leakage	
Prominent bones to back	

Equipment needs in hospital

Mattress type:

Current pressure sores

Site:

Grade:

Dressed with:

Every (no of days):

OR I currently have no pressure sores:

Date:

Positioning in bed:

Equipment needs in bed:

Assistance needs in bed:

Bladder and Bowel management

Bladder method of management:

Intermittent catheterisation:	Yes	No	
Every (no. of hours):	Make:		
Туре:	Size:		
Mitrofanoff:	Yes 🗌	No	
Bladder neck closed off:	Yes	No	
Artificial urinary sphincter:	Yes	No	
Use of pads	Yes	No	
Type of pads	Frequency changed		

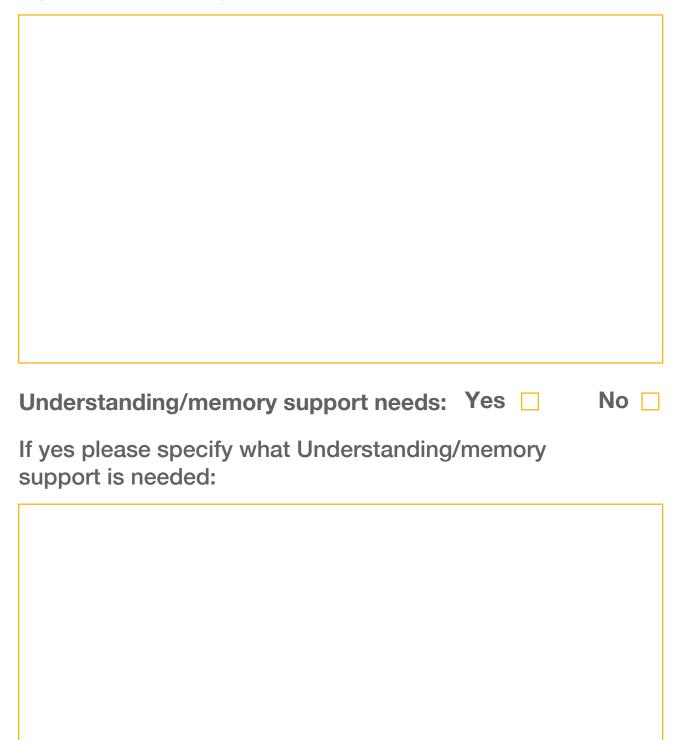
Communication, Cognition and Sensory Information

Languages Spoken:			
First:		Other:	
Interpreter required f	or:		
Hearing impairment:	Yes	No	
User of BSL:	Yes 🗌	No	
Lip reading:	Yes 🗌	No	
Hearing aids:	Yes 🗌	No	
Cochlear implant:	Yes	No	
Communication support needs:			
Vision impairment:	Yes	No	
If yes please specify what support is needed:			

Yes	No	
Method of manager	nent:	
S:		
Yes	Νο	
Frequency changed		
	Method of manager	Method of management:

Behaviour support needs:	Yes 🗌	No
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If yes please specify what behaviour support is needed:



Mental Wellbeing

Information:

Support needs:

Other Daily Living Activities

Assistance needs:

Washing/bathing:

Dressing:

Using toilet:

Eating:

Drinking:

Current Assistance/Care package

Care manager contact details:

PA contact details:

Agency details:

Continuing Health Care funded:

Yes	7

No

Hours of assistance:

AM:	PM:
Other:	

Additional Information

Likes:

Dislikes: