Attach Patient Sticker here or record

NAME: . . . . . .

NHS NO: | | | | | | | | | | |

HOSP NO: | | | | | | | | | | |

D.O.B: | D | D | M | M | Y | Y | Y | Y | Male ☐ Female ☐

Consultant:..... Ward:.....

Worcestershire NHS
Acute Hospitals NHS Trust

‘ABOUT ME’

Lifestyle and Capabilities Booklet

We would like to invite you to complete the following ‘ABOUT ME’ booklet, which will assist us in ensuring that the care we give to your relative/friend is specific to their needs. Once complete this will be placed in the front of the folder which is kept at your relative/friends bedside.

If you think of any additional information, this can be added at any time. Some prompts have been provided as a guide but if you need any assistance to complete this form, or require interpretation or translation services, please do not hesitate to ask one of the nurses.

My preferred name is:

ONCE COMPLETED PLEASE FILE IN PATIENTS NOTES

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D.O.B: D D M M Y Y Y Y Male ☐ Female ☐

Consultant:..... Ward:.....

COMMUNICATION

- How do they communicate? Verbally, through gestures, withdraws from interacting and communicating?
- Do they respond more to some people rather than others? Who?
- At what time of day do you feel they are most able to communicate?
- Do they use particular actions to demonstrate their thoughts/feelings/desires? If so, please describe: Some examples could include swearing if they need to use the toilet, packing belongings if stressed, calling out if they want help.

Please describe below how best your relative/friend communicates:

EATING AND DRINKING

- Are they able to choose which meal they prefer?
- Eat/drink without prompting, needs prompting, will feed themself.
- Needs food cutting up. Uses adapted cutlery at home. Able to make snacks/drinks at home.
- Prefers ‘finger foods’.
- Needs assistance with being fed.
- What are their preferred drinks?
- What do they particularly like to eat and what are their dislikes?

Please describe below:

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HYGIENE

- Do they usually bath or shower; need prompting; can bath/shower independently.
- Are they able to wash unaided if given a bowl or taken to a bathroom to use a sink/
- Do they wear dentures, please indicate if there are any issues regarding removal of teeth for cleaning (e.g. they are reluctant to remove, cleans mouth with tooth brush).

MOBILITY

- Do they walk steadily and independently without aids?
- Walks steadily or unsteadily with stick or frame; uses furniture to steady self when walking.
- Are they prone to falls; need supervision and assistance.
- Are they restless? do not like to sit still for any length of time.
- Usually goes for a walk every day at the same time.
- Sits safely without supervision; unable to sit without support.
- Needs assistance getting in and out of a chair; (please specify how many people are normally required to assist).
- Needs to be hoisted.

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DRESSING

- Dresses unaided; needs assistance with buttons and zips.
- Needs prompting and help to dress correctly.
- Unable to dress self.

SIGHT AND HEARING

- Are they blind or partially sighted? Can read print in newspapers or books; able to find way around without bumping into objects; can identify light objects.
- Do they have problems with their hearing/ Wear hearing aids in one or both ears; needs to be spoken to clearly or use raised voice.
- Are they deaf? Lip reads. Sign language.

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TOILETING

- Are they fully continent and able to take themselves to the toilet?
- Need to be taken to the toilet?
- Are they unable to control bowels or urine?
- Experiences accidents at night?
- Wears protective pads/clothing.
- Identify if medication or diet taken to keep regular bowel movement?

SLEEP, REST AND DAILY ROUTINE

- Do they wake very rarely at night; wakes regularly at night.
- If they wake most nights describe the frequency and what their usual behaviour is and how they settle. Sleeping position. How many pillows?
- Have they been waking up at night for the past week?
- Do they usually go to bed at a specific time and/or has a specific routine, please describe (e.g. cup of hot chocolate and any prescribed medication to aid sleep).
- What time do they get up at?

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OTHER DETAILS

- Describe any physial symptoms they may have (e.g. post shingles neuralgic pain which gives them headaches and may make combing hair painful; indigestion requiring antacids.
- Do they complain of depression? Do they think other are plotting against them; is there anything in particular which makes them sad, frightened, angry or agitated?
- List family members and/or pets that they are close to and may want to talk about.
- List any hobbies and social activities; regular habits e.g. do they drink or smoke?
- What was/is their occupation; did/do they belong to any committees/clubs?
- How do they usually spend their day?
- What are their favourite TV and radio programmes?
- Do they have favourite CDs which they can listen to? What is their favourite music?
- Do they have a favourite object which keeps them occupied?
- What decisions can they be involved in making e.g. plans for meeting hygiene needs, meals, sharing their thoughts on discharge needs?

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Consultant:..... Ward:.....

Thank you. This information will only be shared with members of staff, volunteers and other care agencies who may be involved with caring for your relative/friend.

Signature of Person completing Form	
Relationship to Patient	
Date:	

ONCE COMPLETED PLEASE FILE IN PATIENTS NOTES