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# **My Health File**

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This file is to help you learn more  
about your health.

It will help when you have appointments  
with Doctors and other health workers.

Please take it with you.

Your Health Facilitator or helper  
can help to fill it in.

You can use it to write down  
your appointments.

You can write down what advice  
you have been given.

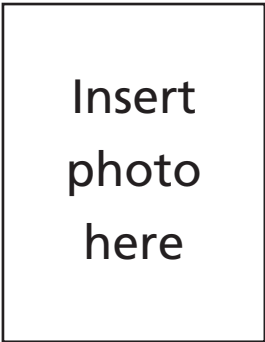
This file can help you remember  
about your health.

Please ask the Health Worker to read this.  
It tells them what to do:

*Health Professionals please fill in  
the sections relevant to you, using  
easy language. Please add  
information that the person can  
use to help them with their health.*

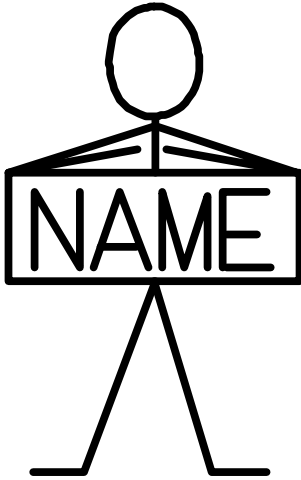
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# My Health File



Insert  
photo  
here

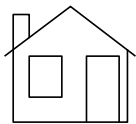
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# Details



My name is



My address is



My date of birth is



My phone number is

# Important information about me.

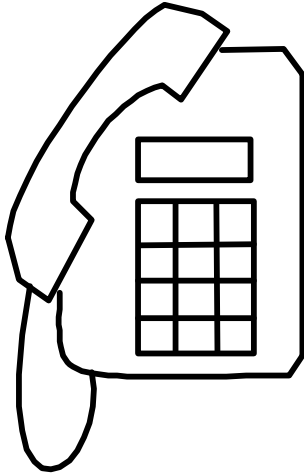


My ethnicity is...



My religion is...

These affect my life or health in the following ways...

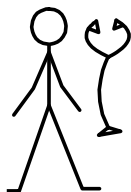


# Contacts

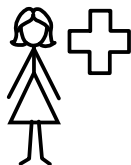
Contact person



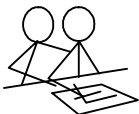
GP



Health facilitator







## People who help me.



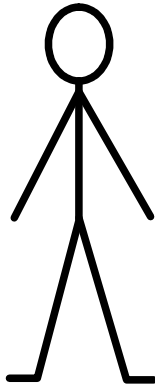
name



who they are



how to contact



About me

# Important information about me.



Allergies

Details...



Asthma



**X**

Diabetes



Epilepsy

other ...

other ...

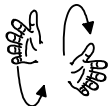
# How to communicate with me



use objects of reference



use facial expressions



use signs (Makaton)



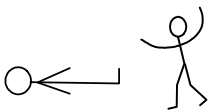
use sentences with key words



use symbols or pictures

other...

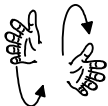
# How I communicate.



by my body



by my facial expressions



by signs (Makaton)



by sounds I make



with symbols or pictures



by what I say.

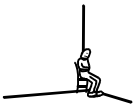
# When I am ill..



I stop eating or drinking



I cry



I sit quietly



I do silly things



I sleep a lot

other...

# My health problem.



pain



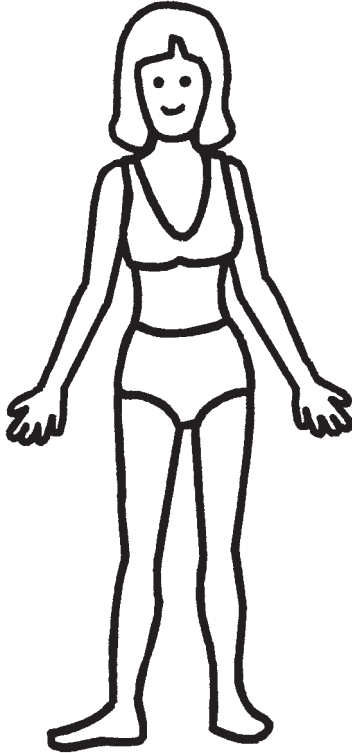
spots



bleeding



bruise



body not working



worried



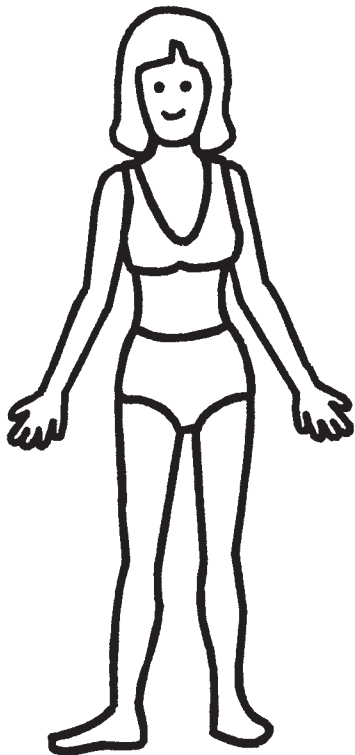
problems moving



Something else

# Treatment.

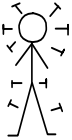
Which part of your body?



What will be done?



# My health problem.



pain



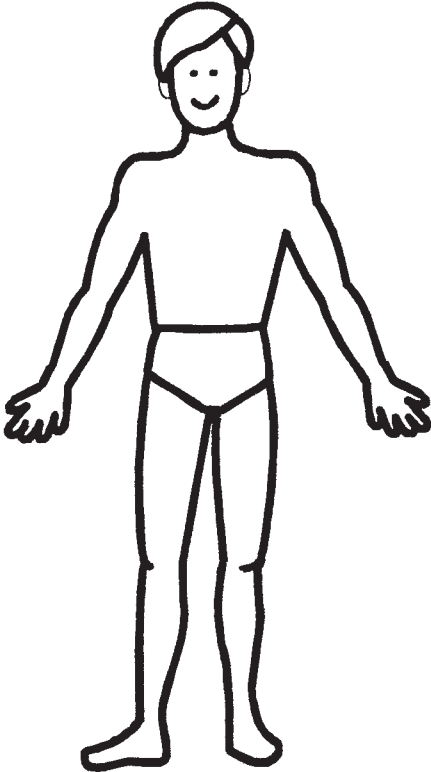
spots



bleeding



bruise



body not working



worried



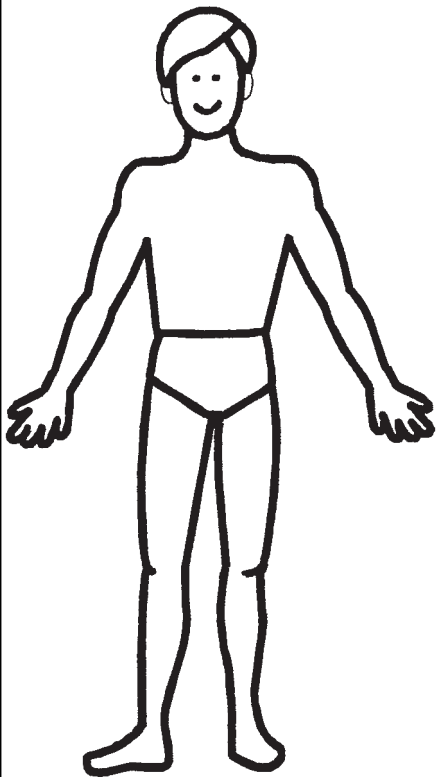
problems moving



Something else

# Treatment.

Which part of your body?



What will be done?

# About eating and drinking.

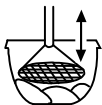


I need a special diet

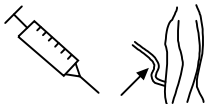
Details..



I need thickened drinks



I have soft mashed food



I have a PEG

other...

other...

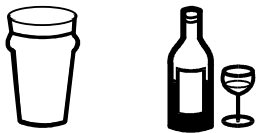
# My lifestyle.



exercise



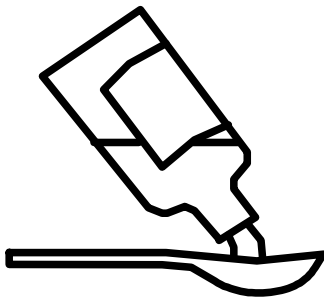
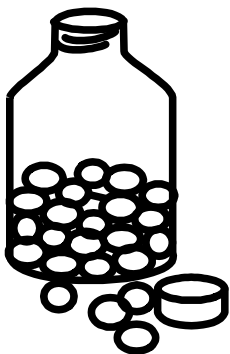
smoking



alcohol

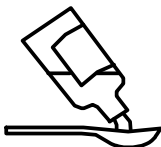
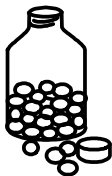


drugs



My medicines





## My medicine

Name

For

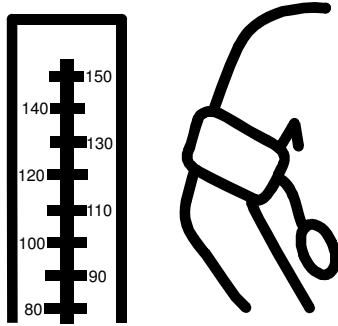
Date

Start  
Stop

How much  
and when?

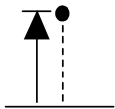
Help I need.

Which doctor  
prescribed it?

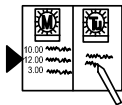


# Check ups





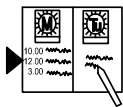
My height is



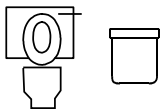
date



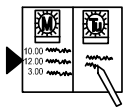
weight



Date



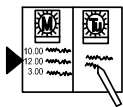
Urine test



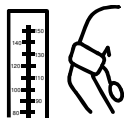
Date



Blood test



Date



blood pressure



About my eyes.



Optician

Details...



Eyesight



Glasses?





## About my ears.



Who tests?

Details...



My hearing



Ears and wax

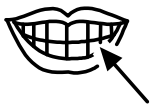


Aid.

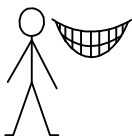








## About my teeth.



My dentist

Details...

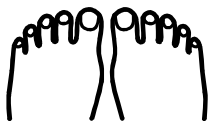


My teeth



My dentures





About my feet.



Chiropodist



My feet



Special shoes





## Contraception.



Prescribed by...



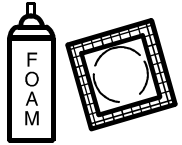
I use...



pills



condoms



cap

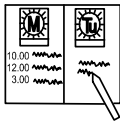


injection

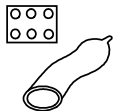


coil

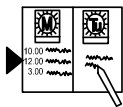
other.



Date



Contraception check.

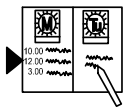


Date

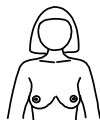


Smear test.



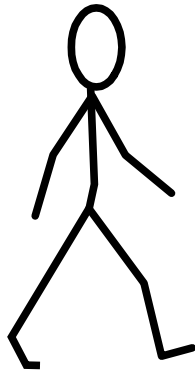


Date



Breast screening





# Mobility



## About my mobility

I use

Details



walking stick



walking frame



wheelchair

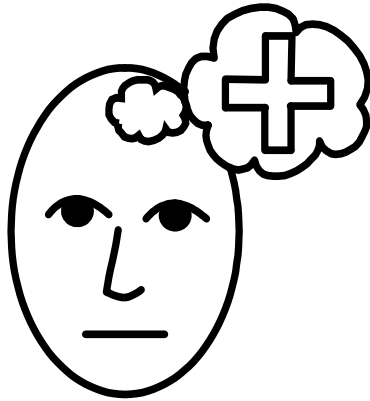


crutches



splint

other



Mental health



# Mental Health

## When I am ill..



I stop eating or drinking



I cry



I sit quietly



I do silly things

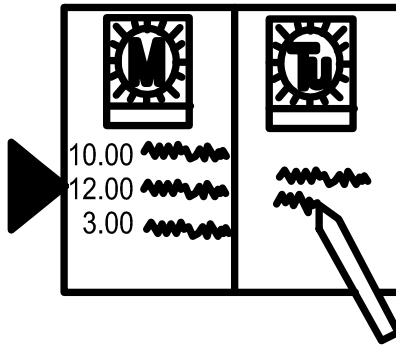


I sleep alot



My consultant

Details...



# Appointment





# Hospital Appointment.



x-ray



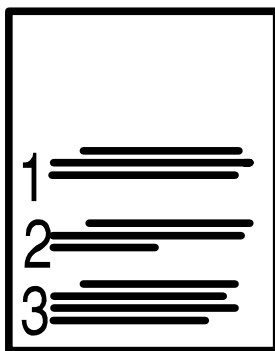
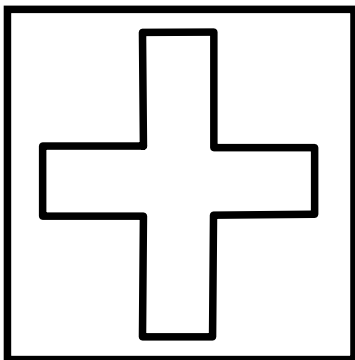
blood tests



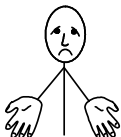
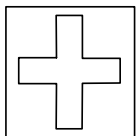
urine test



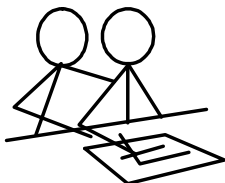
injection



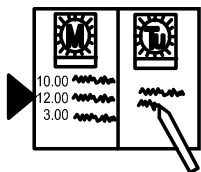
# Health Action Plan



My health need



What will I do?  
Who will help me?



We will look at  
this again on..



# What makes me ill.



medicines



routines



food and drink



activities

other



# How I stay well.



medicines



routines



food and drink



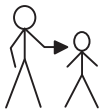
activities

other

# How to help me.



When I do this...



I want you to...

# X

Things I **really** don't want to happen.

# Safe Lifestyles



keep active



have your eyes tested



medication checkup



good food and calcium



look after your feet





take medication on time



non slip shower mat



get up slowly



## HOSPITAL TRAFFIC LIGHT ASSESSMENT

For people with learning disabilities.

This assessment gives hospital staff important information about you.

Please take it with you if you have to go into hospital and give it to the people looking after you.

Please note: **Value judgements** about quality of life and healthcare must be made in consultation with you, your family, carers and other professionals, following the principles of the **Mental Capacity Act (2005)**.

**It is Important ALL the hospital staff who look after you read this assessment.**

# RED-ALERT

## Things you must know about me

Name - NHS number -  
Likes to be known as -  
Address - Tel no-  
Date of Birth -  
GP - Address:  
Next of Kin - relationship - Tel no -  
Key worker/main carer - relationship - Tel no -  
Professionals involved - Tel no -  
Religion - Religious requests -

### Allergies:

My current medical conditions including medication, doses and times taken:

Medical Interventions - how to take my blood, give injections, etc

Do you know if I have made a valid Advance Directive? YES/NO  
Do I have a Lasting Power of Attorney for personal welfare? YES/NO

Heart (heart problems) YES/NO Breathing (respiratory problems) YES/NO  
Epilepsy YES/NO Gastric Disorders YES/NO

**Communication** -

How to communicate  
with me.

**Information sharing** -

How to help me  
understand things.

**Seeing/hearing** -

Problems with sight  
or hearing

**Eating (swallowing)** -

Food cut up, choking,  
help with feeding.

**Drinking (swallowing)** -

Small amounts,  
choking

**Going to toilet** -

Continence aids,  
help to get to toilet.

**Moving around** -

Posture in bed,  
walking aids.

**Taking medication** -

Crushed tablets,  
injections, syrup

**Pain** -

How you know  
I am in pain

**Sleeping** -

Sleep pattern,  
sleep routine

**Keeping safe** -

Bed rails, controlling  
behaviour, absconding

**Personal care** -

Dressing, washing etc.

**Level of support** -

Who needs to stay  
and how often.

**GREEN**

## My likes and dislikes

Think about - what upsets you, what makes you happy, things you like to do i.e. watching TV, reading, music. How you want people to talk to you. Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.

THINGS I LIKE



THINGS I DON'T LIKE



Please do this:

Don't do this:

Completed by: .....

Date:.....

If you want to know more about the file ring

Jackie Fleeman (01332 268455)

Marsha Kerrigan (01332 268455)

or Joe Pacey (01246 565000)

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**[www.widgit.com](http://www.widgit.com)**



'My Health File' has been produced in partnership with Derbyshire and Derby City Learning Disability partnership boards and the Co-operative Group, Central and Eastern region.

With thanks to Ilkeston Manufacturing Services (IMS)  
for their help with assembling the files.