Hospital Passport

Name:

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

Shine
Spina bifida • Hydrocephalus
Information • Networking • Equality

General Information

First Name:

Last Name:

Would like to be called:

NHS Number:

DOB:

Address:

Address line 2:

Town:

Post code:

Telephone No.:

Mobile No.:

Email:

Next of kin:

Power of Attorney: Yes ☐ No ☐

Details:

Deprivation Of Liberty orders: Yes ☐ No ☐

Religion (if any):

GP Name:

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:

Communication, Cognition and Sensory Information

Languages Spoken:

First:

Other:

Interpreter required for:

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 information:

Behaviour support needs:

Understanding/memory support needs:

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:

Dressed with:

Every (no of days):

OR I currently have no pressure sores: ☐

Date:

Health Information

Current Medication:

Medical History

Neurosurgery:

Neurology:

Orthopaedics/spinal:

Urology:

Colorectal:

Respiratory:

Adverse reaction to anaesthetic: Yes ☐ No ☐

Hydrocephalus information

Shunt: Yes ☐ No ☐

Type:

Programmable: Yes ☐ No ☐

ETV: Yes ☐ No ☐

Mobility information

Stands to transfer: Yes ☐ No ☐

Mobility Aids:

Uses a hoist: Yes ☐ No ☐

Uses a sliding board or other to transfer: Yes ☐ No ☐

Mobility Aids:

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:

Type:

Size:

Mitrofanoff: Yes ☐ No ☐

Bladder neck closed off: Yes ☐ No ☐

Use of pads Yes ☐ No ☐

Type

Stoma: Yes ☐ No ☐

Bag details

Bowel Management:

Open every (no. of days):

Method of management:

Transanal irrigation (type):

Assistance/equipment needs:

Use of pads: Yes ☐ No ☐

Type

Stoma-bag details:

Mental Wellbeing

Information:

Support needs:

Other Daily Living Activities

Assistance needs:

Washing/bathing:

Dressing:

Using toilet:

Eating:

Drinking:

Taking medication:

Current Assistance/Care package

Care manager contact details:

PA contact details:

Agency details:

Continuing Health Care funded: Yes ☐ No ☐

Hours of assistance:

AM:

PM:

Other:

Additional Information

Likes:

Dislikes: