Please affix patient label or complete details below.

Full name:

Hospital number:

NHS number:

DOB:

NHS
Papworth Hospital
NHS Foundation Trust

All About Me

Self assessment questionnaire

Please complete and bring with you to your next appointment at Papworth Hospital

Please provide us with as much information as possible. If you are unsure about anything, please ask your healthcare provider.

Your details

Preferred or first name:

Family name:

Date of birth: / / Country of birth:

Preferred language: Interpreter required: ☐ Yes ☐ No

Home address:

Postcode:

Home number: Mobile number:

Emergency contact

Preferred or first name:

Family name:

Relationship to you:

Preferred language: Interpreter required: ☐ Yes ☐ No

Address:

Postcode:

Home number: Mobile number:

Details of intended operation – to be filled in by your healthcare professional

Date of operation or referral to treatment target: / /

Type of operation:

Name of consultant:

Print name: Signature:

Designation: Date: / / Time: :

We need to have a further understanding of your recuperating environment. Some answers will need you to write down measurements: If you are unable to do this please ask a friend or relative to help. Please tick the Yes or No boxes and write down any further information in the spaces provided. There is additional space on page 10 if you need it.

Who lives with you

Do you live alone? ☐ Yes ☐ No

If no, do you live with your: ☐ Spouse/Partner ☐ Relative ☐ Other

Is he/she fit and well? ☐ Yes ☐ No

If no, please provide details:

Are they able to support you on discharge? ☐ Yes ☐ No

If not, who will support you?

Do you look after another person? ☐ Yes ☐ No

If yes, please provide details: Age:

Transport

Who will take you home from hospital when you are discharged? Please provide contact details:

Name:

Home number: Mobile number:

Your home

Do you live in a: (please tick)

☐ House (with stairs)

☐ Bungalow (one storey building)

☐ Flat/apartment/ maisonette

Which floor? .....

☐ Warden/sheltered home

☐ Homeless

☐ Other e.g. retirement home or caravan:

Are you planning on returning to your own home after surgery? ☐ Yes ☐ No

If no, please state where you plan to go (include address & contact details):

Inside your home – heating

Heating: (please tick all that apply)

☐ Central heating

☐ Gas fire

☐ Electric fire

☐ Solid fuel

☐ Oil

Other (please specify):

Inside your home – accessibility

Do you have: (please tick all that apply)

☐ Front door steps How many? Is there a support rail? ☐ Yes ☐ No

☐ Back door steps How many? Is there a support rail? ☐ Yes ☐ No

☐ Stairs How many? Is there a support rail? ☐ On the left ☐ On the right ☐ Both sides ☐ No

Do any of the rails stop part way up the stairs? ☐ Yes ☐ No

If yes, please state where:

Is there a lift to your accommodation? ☐ Yes ☐ No

Does it usually work? ☐ Yes ☐ No

Do you have a stair lift? ☐ Yes ☐ No

Does it go all the way up the stairs? ☐ Yes ☐ No

If no, please provide details:

Do you have any other additional steps within your home? ☐ Yes ☐ No

If yes, please provide details:

Do you currently have difficulty getting up or down stairs? ☐ Yes ☐ No

If yes, please provide details:

Are there any steps outside your home? ☐ Yes ☐ No

If yes, please provide details:

If you are going to family or friends please provide the measurements for your furniture as well as theirs. There is additional space on page 10 if you need it.

Inside your home – toilet

Where is your toilet: (please tick all that apply)

☐ Upstairs ☐ Downstairs ☐ Outside ☐ Other (specify):

Do you have difficulty getting on or off the toilet? ☐ Yes ☐ No

What is the height of the toilet from floor to seat with the seat down?
(If you have a raised toilet seat, measure with this on)

Upstairs toilet: ☐ cm ☐ inches (please specify)

Downstairs toilet: ☐ cm ☐ inches (please specify)

Do you have a raised toilet seat or any other equipment around your toilet, e.g. grab rails?

☐ Yes ☐ No If yes, please specify:

Inside your home – bathing

Where is your bathroom: (please tick all that apply)

☐ Upstairs ☐ Downstairs ☐ Other (specify):

Do you normally: (please tick all that apply)

Bath ☐ Yes ☐ No Strip wash seated ☐ Yes ☐ No

Shower ☐ Yes ☐ No Strip wash standing ☐ Yes ☐ No

If you shower, is it a: ☐ Wetroom ☐ Cubicle ☐ Shower over bath

If a cubicle, how high is the step and what are the dimensions of the shower tray?

width: height:

Do you use a commode? ☐ Yes ☐ No

If yes, what is the height of the seat from the floor?

☐ cm ☐ inches (please specify)

If yes, who empties it for you?

Do you have difficulty washing and/or dressing yourself? ☐ Yes ☐ No

If yes, please provide details:

Inside your home – bedroom

Where is your bedroom: (please tick all that apply)

☐ Upstairs ☐ Downstairs ☐ Other (specify):

Is your bed?

☐ Single bed
☐ Divan

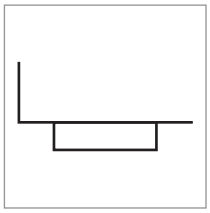
☐ Double bed
☐ Divan

☐ Sofa bed

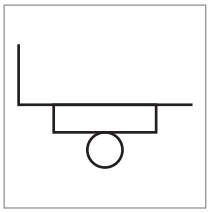
☐ Electric bed

Other (please specify):

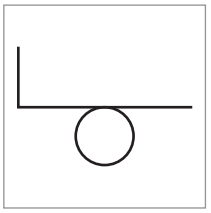
Which diagram best reflects the legs on your bed?



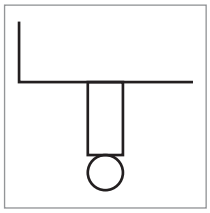
☐ A



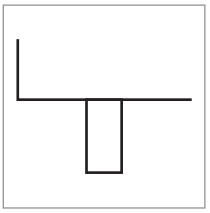
☐ B



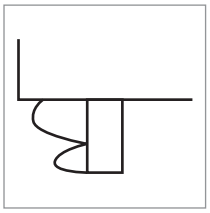
☐ C



☐ D



☐ E



☐ F

Do you have difficulty getting on the bed? ☐ Yes ☐ No

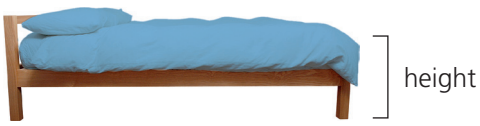
Do you have difficulty getting off the bed? ☐ Yes ☐ No

Do you have any equipment to help you get on/off the bed? ☐ Yes ☐ No

If yes, please give details:

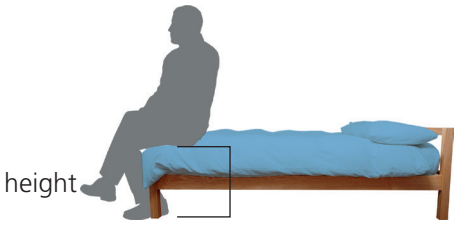
What is the height of your bed from the floor to the top of the mattress?

☐ cm ☐ inches (please specify)



What is the height of your bed from the floor to the mattress when someone is sitting on it?

☐ cm
☐ inches
(please specify)



If necessary is there space to bring your bed downstairs? ☐ Yes ☐ No

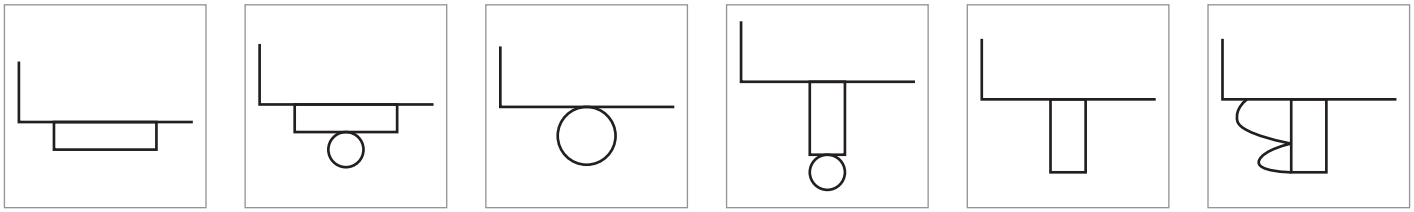
If yes, and you need to have your bed moved downstairs, whom can we contact to arrange this while you are in hospital?

Name: Relationship to you:

Contact number 1: Contact number 2:

Inside your home – furniture

Which diagram best reflects the legs on your chair?



☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

How high off the floor is the seat of your chair(s) when someone is sitting on it?
(Tick and answer all that apply)

Do you use an armchair?
☐ Yes
☐ No

height

If yes, provide height details below:

☐ cm ☐ inches (please specify)

Does it have arms? ☐ Yes ☐ No

Is the armchair ☐ Firm ☐ Soft

Does the chair recline ☐ Yes ☐ No

If yes, does it have a ☐ manual recline ☐ electric recline

Do you use a settee?
☐ Yes
☐ No

height

If yes, provide height details below:

☐ cm ☐ inches (please specify)

Does it have arms? ☐ Yes ☐ No

Is the settee ☐ Firm ☐ Soft

Do you use a dining chair?
☐ Yes
☐ No

height

If yes, provide height details below:

☐ cm ☐ inches (please specify)

Does it have arms? ☐ Yes ☐ No

Is the dining chair ☐ Firm ☐ Soft

Other? Draw a description:
☐ Yes
☐ No

If yes, provide height details below:

☐ cm ☐ inches (please specify)

Does it have arms? ☐ Yes ☐ No

Is the chair ☐ Firm ☐ Soft

Everyday life at home – meal preparation

Are you able to prepare your meals independently? ☐ Yes ☐ No

If you are unable to prepare your meals, do you have someone to do this for you? ☐ Yes ☐ No

If yes, please specify who:

Name: Relationship to you:

Contact number 1: Contact number 2:

Do you use Meals on Wheels? ☐ Yes ☐ No

Do you have a microwave? ☐ Yes ☐ No

Do you use a private frozen foods delivery service? ☐ Yes ☐ No

If yes, please provide details:

Everyday life at home – domestic activities

Do you do your own shopping? ☐ Yes ☐ No

If no, please provide details:

If yes, who have you agreed will be helping you with your shopping when you leave hospital? Specify:

Name: Relationship to you:

Contact number 1: Contact number 2:

Do you do your own cleaning/housework? ☐ Yes ☐ No

If no, please provide details:

If yes, who will be helping you with your cleaning/housework when you leave hospital? Specify:

Name: Relationship to you:

Contact number 1: Contact number 2:

Have you discussed this with them? ☐ Yes ☐ No

Do you do your own laundry? ☐ Yes ☐ No

If no, please provide details:

If yes, who will be helping you with your laundry when you leave hospital? Specify:

Name: Relationship to you:

Contact number 1: Contact number 2:

Have you discussed this with them? ☐ Yes ☐ No

Everyday life at home – care management

Do you have a social worker / care manager? ☐ Yes ☐ No

If yes, please specify who:

Name: Contact number:

Have you ever seen an occupational therapist in the community? ☐ Yes ☐ No

If yes, please specify who:

Name: Contact number:

Does the district nurse visit you at home? ☐ Yes ☐ No

If yes, what type of service does he/she provide:

If yes, please specify who:

Name: Contact number:

Everyday life

Do you have a job? ☐ Yes ☐ No

If yes, please tell us what you do:

What leisure activities do you do?

Mobility

	Indoors	Outdoors	N/A
One walking stick	☐ Yes ☐ No	☐ Yes ☐ No	☐
Two walking sticks	☐ Yes ☐ No	☐ Yes ☐ No	☐
One crutch	☐ Yes ☐ No	☐ Yes ☐ No	☐
Two crutches	☐ Yes ☐ No	☐ Yes ☐ No	☐
Zimmer frame without wheels	☐ Yes ☐ No	☐ Yes ☐ No	☐
Zimmer frame with wheels	☐ Yes ☐ No	☐ Yes ☐ No	☐
Wheelchair	☐ Yes ☐ No	☐ Yes ☐ No	☐
Independent	☐ Yes ☐ No	☐ Yes ☐ No	☐
Other (specify):	☐ Yes ☐ No	☐ Yes ☐ No	☐

How many minutes can you walk for?

Please write any questions you have or extra information relating to the answers you have already given in the space below.

Healthcare Professional Summary – to be filled in by your healthcare professional

Name:

Profession:

Ext/Bleep:

Referred for Discharge Assessment on ICE? ☐ Yes ☐ No

Date Completed:

Completion of this booklet will enable us to appropriately plan ahead for your safe discharge by identifying what your potential needs may be and to ensure that leaving hospital and going on to your recuperating environment will be as smooth as possible.

It will assist us to plan care management and pre-empt any equipment or services you may need to enhance with your recovery.

To reduce the repetition of information collected, it may be necessary to share this information with clinicians within the hospital, with other areas of the NHS or with relevant support agencies to ensure that your continued care is as efficient as possible.

Please ensure you bring this completed booklet with you to your appointment at Papworth Hospital.

If you have any problems with completing this booklet, please contact Papworth Preadmission Clinic on **01480 364100**.

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SMOKEFREE Papworth Hospital is a smokefree site

Author ID: Cardiac Support Team, Occupational Therapy, Physiotherapy, Cardiac Surgery, Advanced Nurse Practitioners, Directorate of Nursing.
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Large print copies and alternative language versions of this leaflet can be made available on request.