

Please affix patient label or complete details below.

Full name: _____

Hospital number: _____

NHS number: _____

DOB: _____



Royal Papworth Hospital
NHS Foundation Trust

All About Me

Self assessment questionnaire



Please complete and bring with you to your next appointment at Royal 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:

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 on the following page and write down any further information in the spaces provided. There is additional space on page 11 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:

Do you wear a personal alarm/falls alarm? Yes No

Do you have a key safe outside your home? Yes No

Transport

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

Name: _____



Home number: _____ Mobile number: _____

Do you drive? Yes No

Do you have a blue badge? Yes No

Your home

Do you live in a: (please tick)

	<input type="checkbox"/> House (with stairs)		<input type="checkbox"/> Bungalow (one storey building)		<input type="checkbox"/> Flat/apartment/maisonette		<input type="checkbox"/> Warden/sheltered home
<input type="checkbox"/> Homeless		Which floor?					
<input type="checkbox"/> 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)

- | | | | | |
|---|-----------|--------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Front door steps | How many? | Is there a support rail? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Back door steps | How many? | Is there a support rail? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Stairs | | Is there a banister? | <input type="checkbox"/> On the left | <input type="checkbox"/> On the right |
| | | | <input type="checkbox"/> No | |

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

If yes, please state where:

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

If yes, please provide details:

Do you have a stair lift? Yes No

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

If no, please provide details:

Is there a lift to your accommodation? Yes No

Does it usually work? Yes No

Do you have any other additional steps inside 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 11 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)



Is your toilet free-standing (as shown in the image above) or built into a vanity unit?

Free-standing Unit

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

Shower Yes No

Strip wash seated Yes No

Strip wash standing Yes No

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

If it is a shower over the bath, what is the width of the bath (from the tiled wall to the near-side edge)?
 width:

If a cubicle, what are the dimensions of the shower tray?

width: length:

Is it ceramic or plastic? Ceramic Plastic

If there is a step, how high is it?

height: No step

Is there a shower seat or stool, how high is it?

height: No seat/stool



Would you have space in front of the basin for a stool? Yes No

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



Double bed



Sofa bed

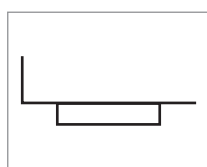


Electric bed

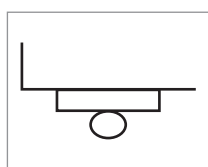
Divan Slatted Divan Slatted

Futon bed/flat with no legs Other (please describe):

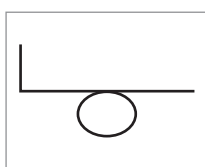
Which diagram best reflects the legs on your bed?



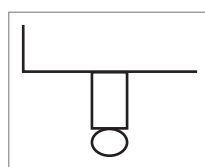
A



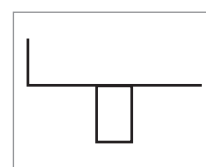
B



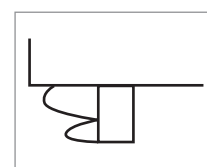
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Do you have difficulty getting on the bed?

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)



Number of legs/casters:

Diameter:

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:

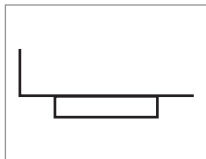
Relationship to you:

Contact number 1:

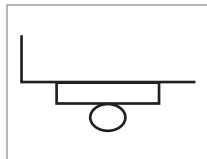
Contact number 2:

Inside your home – furniture

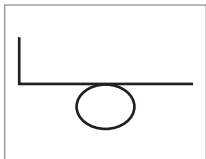
Which diagram best reflects the legs on your chair?



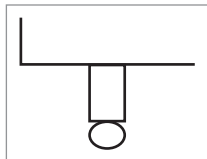
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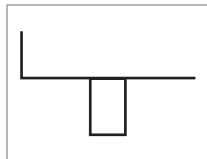
B



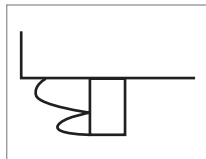
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How high off the floor is the seat of your chair(s) WHEN SOMEONE IS SITTING ON IT?
 (Tick and answer all that apply)

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
 or is it a riser recliner chair? Yes No

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

Does the sofa recline? Yes No

How many legs does the sofa have? Yes No

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:

Do you have a chair and table to eat in your kitchen if necessary? Yes No

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: _____

Do you have a care package? Yes No

Is it provided by social services or privately funded? social services or privately funded

How many calls do you receive per day?

What do they assist with?

Everyday life

Do you have a job? Yes No

If yes, please tell us what you do:

.....
.....
.....
What leisure activities do you do?

Do you have any pets at home? Yes No

What are they?

Mobility

	Indoors	Outdoors	N/A
One walking stick	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Two walking sticks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
One crutch	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Two crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Zimmer frame without wheels	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Zimmer frame with wheels	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Independent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

How many minutes can you walk for?

Have you fallen over in the past 12 months? Yes No

If yes, how many times?

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

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 Royal Papworth Hospital.

If you have any problems with completing this booklet, please contact Papworth Preadmission Clinic on **01223 638408**.

Royal Papworth Hospital NHS Foundation Trust

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