

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:

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

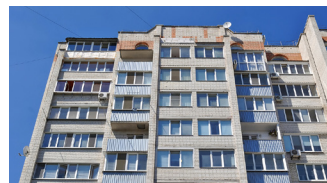
Do you live in a: (please tick)



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)

- | | | | | |
|---|-----------|--------------------------|--------------------------------------|---------------------------------------|
| <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 | How many? | Is there a support rail? | <input type="checkbox"/> On the left | <input type="checkbox"/> On the right |
| | | | <input type="checkbox"/> Both sides | <input type="checkbox"/> 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

Double bed

Sofa bed

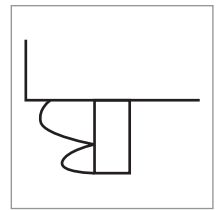
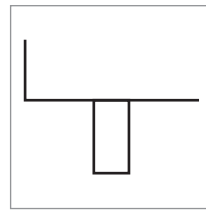
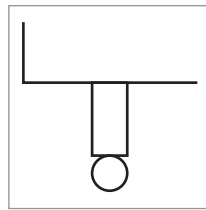
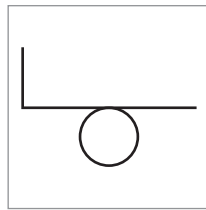
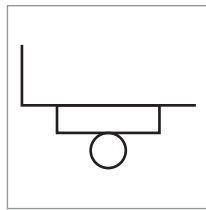
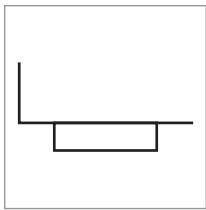
Electric bed

Divan

Divan

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

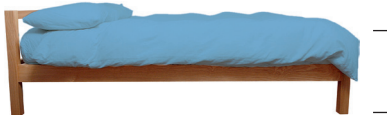
Do you have difficulty getting off the bed? Yes No

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

If yes, please give details:

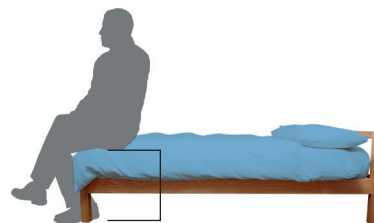
What is the height of your bed from the floor to the top of the mattress?

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

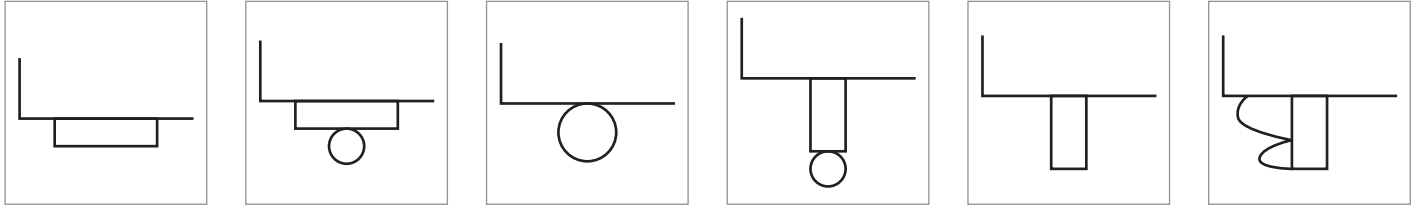
If yes, and you need to have your bed moved downstairs, whom can we contact to arrange this while you are in hospital?

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



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



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



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

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?

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 638100**.

Royal Papworth Hospital NHS Foundation Trust

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