

Please affix patient label or complete details below.

Full name: _____

Hospital number: _____

NHS number: _____

DOB: _____



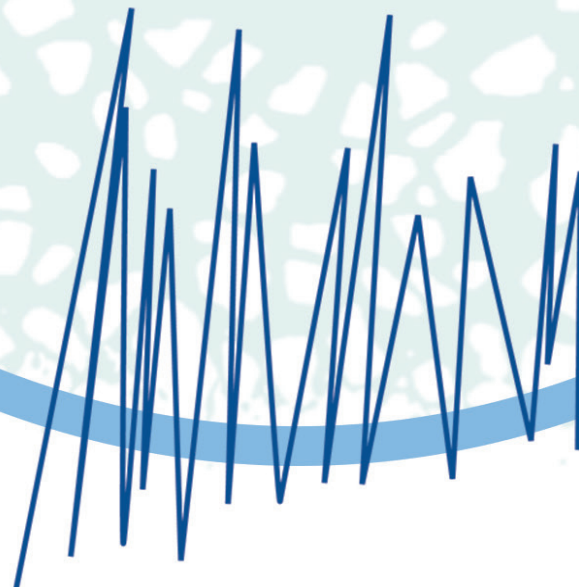
Royal Papworth Hospital
NHS Foundation Trust

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 15 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

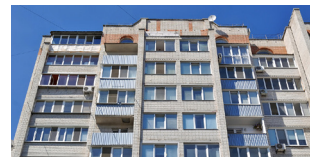
Do you live in a: (please tick)



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

Is there a banister? On the left
 On the right

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 15 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:

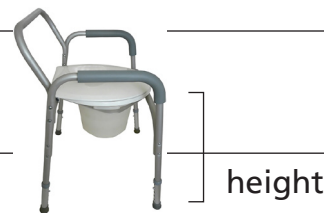
Is it ceramic or plastic? Ceramic Plastic

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

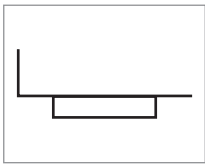


Electric bed

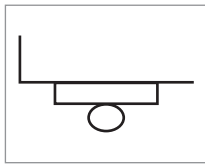
Divan Slatted Divan Slatted

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

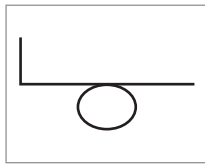
Which diagram best reflects the legs on your bed?



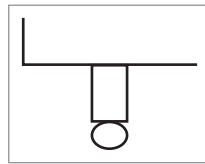
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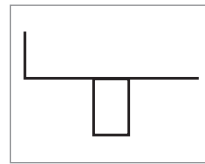
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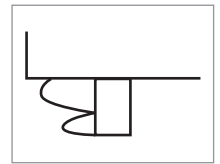
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Do you have difficulty getting on the bed?

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:

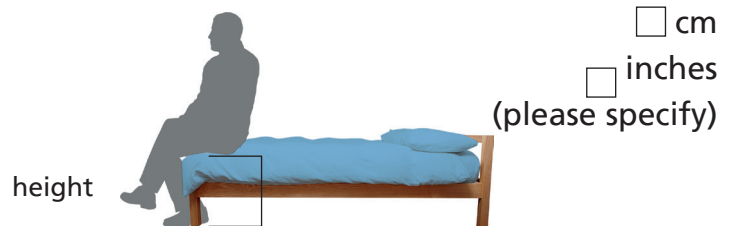
What is the height of your bed from the floor to the top of the mattress?

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:

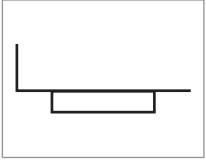
Relationship to you:

Contact number 1:

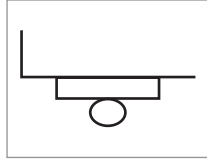
Contact number 2:

Inside your home – furniture

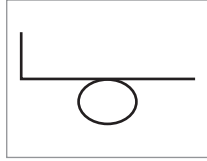
Which diagram best reflects the legs on your chair?



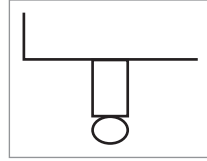
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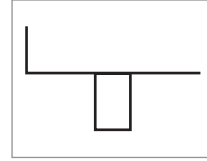
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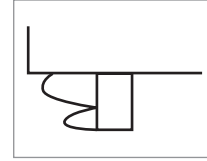
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How high off the floor is the seat of your chair(s) WHEN SOMEONE IS SITTING ON IT?
(Tick and answer all that apply)

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?
Please 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?
Please 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?

Planning for emergencies

How would you describe your current health and fitness level?

.....

.....

.....

Is there anything specific about your health or personal situation that you would like your medical team to know?

.....

.....

.....

Do you have any cultural, spiritual, or religious beliefs that may influence your healthcare decisions or preferences?

.....

.....

.....

Have you had a previous discussion about what you want to happen in an emergency? If so, do you have any written documents outlining these discussions eg ReSPECT form (see page 16), legal power of attorney for health, advanced care plan, advance directive.

.....

.....

.....

In emergency situations, we may contact your next-of-kin to help us better understand your wishes and treatment priorities. Who would you like to be involved in making decisions for you in emergency situations?

Name:.....

Relationship to you:.....

Contact number 1:.....

Contact number 2:.....

What matters to you most in decisions about your treatment and care in the case of an emergency?

.....
.....
.....

What do you value most and what would you most wish to avoid?

.....
.....
.....

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 Royal Papworth preadmission clinic on 01223 638408.

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

Recommended summary plan for emergency care and treatment (ReSPECT)

What is ReSPECT?

ReSPECT stands for 'Recommended summary plan for emergency care and treatment'. It is a process that helps people to think about what treatment is suitable in an emergency, should they be unable to make decisions at the time.

Why is it important?

We know that, when people are very unwell, they are often unable to think clearly about what treatment they may or may not want because their brain and body are overwhelmed by the illness. It is also normal for people to feel anxious about what is happening when they are sick and in hospital, and this can also make it difficult to think clearly. This is why we think it is a good idea, where possible, for decisions about medical treatment to be made in advance – before there is an emergency situation or crisis.

How does it work?

The ReSPECT process is designed to help conversations between you and your healthcare professionals: they need to make sure you understand your health problems and which treatments may or may not benefit you. You need to make sure the healthcare professionals understand what matters most to you and whether there is anything you are particularly worried about or would want to avoid.

This conversation is used to complete a ReSPECT form that records a person's health problems, their preferences and which medical treatments may or may not be suggested. The original form should stay with the patient, though it is extremely helpful to have a record of the content of the form on their electronic patient record.

A ReSPECT form is NOT a legally binding document and can be changed or withdrawn at any point.

The ReSPECT form is often used to indicate treatments that someone may not want and/or treatments that their healthcare professionals consider would no longer be of benefit to them.

If people are getting worse from progressive conditions, it may be helpful to consider in advance about things such as whether they would wish to go back into hospital and, if in hospital, what sort of treatments might or might not be helpful for them.

This often includes a decision on whether or not they should have attempted cardiopulmonary resuscitation (CPR) if their heart was to stop.

Who is it for / is this relevant for me?

This process has increasing relevance for people who have complex health needs, people who may be nearing the end of their lives and those who are at risk of sudden deterioration or cardiac arrest.

However, many people come to Royal Papworth to have major procedures or surgery with the intention of curing a progressive disease or with the intention of substantially prolonging their life and, if that is you, you may wonder how a ReSPECT discussion applies to you and others like you. One of the key things to understand about the ReSPECT process is that it can be used simply to document a person's wishes and priorities, without setting any limitations on what treatment they should have.

This is important because all the procedures and operations we do here come with the risk of complications. In the unlikely event that things do not go as planned, it is really helpful to have some idea about a person's preferences and about their fears, worries and hopes.

Once again, the document is not legally binding, but it can help those looking after you to know what you might want if you weren't able to say for yourself.



Royal Papworth Hospital NHS Foundation Trust

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Large print copies and alternative language versions of this leaflet can be made available on request.

View a digital version of this leaflet by scanning the QR code.



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