Please affix patient label or complete details below.

Full name: ____________________

Hospital number: ____________________

NHS number: ____________________

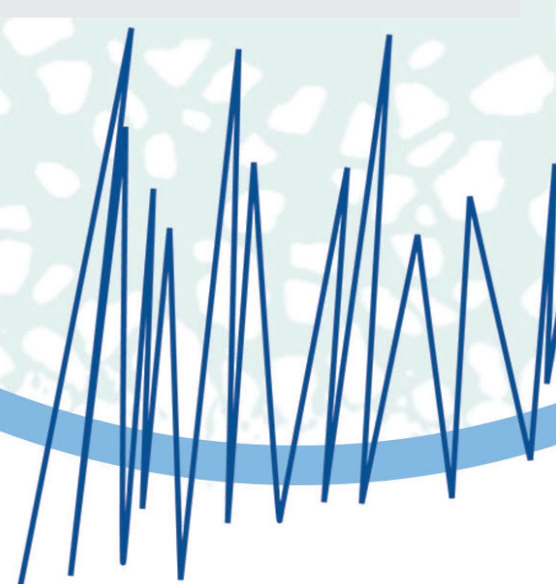
DOB: ____________________

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

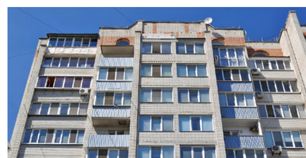
Do you have a blue badge? ☐ Yes ☐ No

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 do
(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):

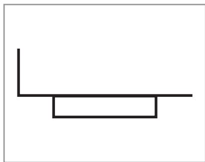
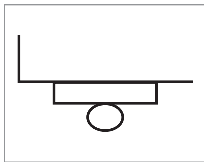
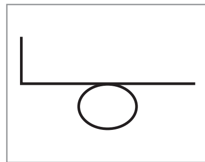
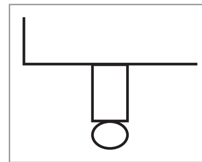
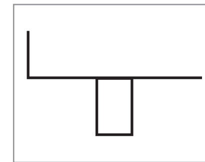
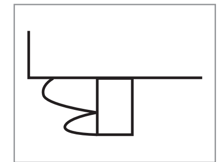
Is your bed?

☐ 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 ☐ 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:

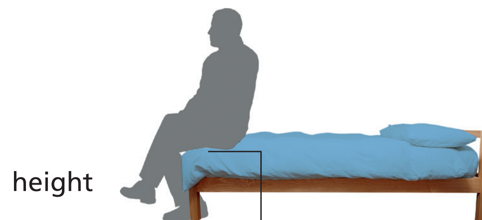
What is the height of your bed from the floor to the top of the mattress?

☐ 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)



Number of legs/casters: Diameter:

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

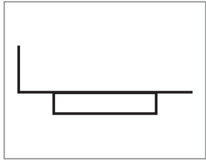
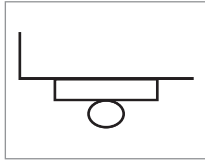
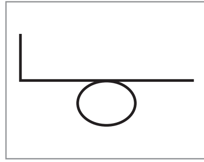
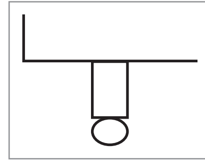
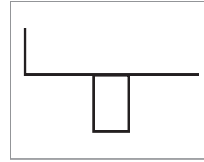
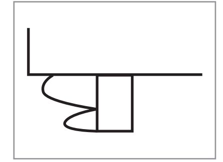
If yes, and you need to have your bed moved downstairs, whom can we contact to arrange this while you are in hospital?

Name: Relationship to you:

Contact number 1: Contact number 2:

Inside your home – furniture

Which diagram best reflects the legs on your chair?

☐ 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
or is it a riser recliner chair? ☐ Yes ☐ No

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
Does the sofa recline? ☐ Yes ☐ No
How many legs does the sofa have? ☐ Yes ☐ No

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:

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	☐ 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?

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 (e.g. ReSPECT form, 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.

Royal Papworth Hospital NHS Foundation Trust

A member of Cambridge University Health Partners

Papworth Road
Cambridge Biomedical Campus
CB2 0AY

royalpapworth.nhs.uk

01223 638000

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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