South Devon Healthcare NHS
NHS Foundation Trust

Recognition of Specific Requirements

Patient ID Label or

Patient Name……..……

DOB……../……../……..

Hospital /MRN Number……

NHS Number……

Do you require an Interpreter? ☐
Do you have a Carer? ☐
Is your Carer in attendance? ☐

Do you have a Red Book? ☐
Do you have a Yellow Folder? ☐
Do you require help after discharge? ☐

Do you wish your carer to have copies of letters/appointments **Yes** ☐ **No** ☐

I have a specific requirement as indicated below:

SENSORY

Hearing

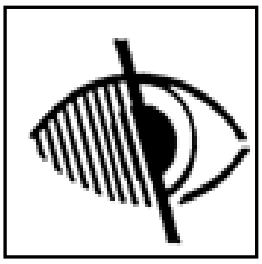
- Deaf ☐
- Lip Reading ☐
- British Sign Language user ☐
- Lip Speaker required ☐
- Hearing Dog ☐
- Book an Interpreter ☐
- Usher Required ☐

Partial Loss of Hearing

- Hard of Hearing ☐
- Deaf in one ear only (left) ☐
- Deaf in one ear only (right) ☐

Hearing Aid

- Left Ear ☐
- Right Ear ☐
- Both Ears ☐

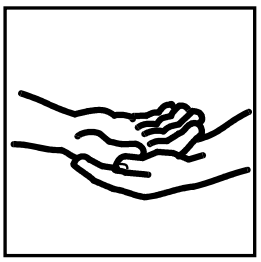


Sight

- Blind ☐
- Reads Braille ☐
- Guide Dog ☐
- Manual Interpreter ☐
- Usher Required ☐

Partial Loss of Sight

- Blind in one eye only (left) ☐
- Blind in one eye only (right) ☐
- Glasses/Contacts ☐
- Large Print ☐
- Audio Description ☐
- Prosthetic Eye ☐
- Visually Impaired ☐



Communication

- Problem with Speech ☐
- Use communication aids ☐
- No verbal communication ☐

PHYSICAL

Unable to walk

- Motorised Wheelchair ☐
- Manual Wheelchair ☐

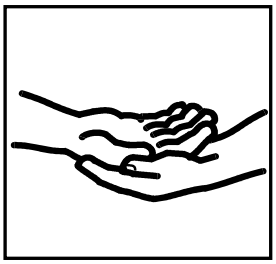
Paralysed one side

- Left ☐
- Right ☐

Difficulties with walking

- Motorised Wheelchair ☐
- Manual Wheelchair ☐
- Unable to walk long distances ☐
- Falls ☐

- Walking Stick Left ☐
- Walking Stick Right ☐
- Walking Stick Both ☐
- Walking Frame ☐



LEARNING DISABILITY

Would you like to bring any additional support requirements to the attention of staff about how they should care for you?

Do you have a learning disability?	Please Tick	☐		
Please contact the Liaison Nurse	Please Tick	☐		
Do you have a Life Story Book?	Please Tick	☐		
Do you have a Patient Profile on file at Torbay Hospital?	Yes	☐	No	☐
If no, does a Patient Profile need to be completed?	Yes	☐	No	☐

If Yes, a Patient Profile does need to be completed, please refer to Appendix A of this form.

Is there anything that you need extra help with?
eg. difficulties with communication or assistance required with Activities of Daily Living (ADL's)

_____

_____

_____

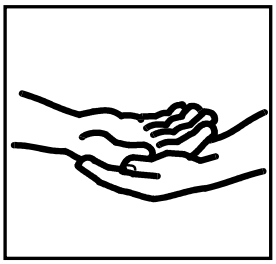
_____

_____

_____

_____

_____



ADDITIONAL SUPPORT NEEDS

e.g. Assistance with communication, Special equipment required.

_____

_____

_____

_____

_____

_____

_____

In order for us to care for you properly during your hospital stay, we would like your permission to put your specific requirements information on the Patient Administration System (PAS), your hospital notes, and above your hospital bed.

I agree to having a card with the symbol indicated above being placed on the outside of my hospital medical record: Yes ☐ No ☐

I agree to having a sign with details of my specific requirements placed above my bed if I am admitted to hospital: Yes ☐ No ☐

Please inform a member of staff if you wish to withdraw your permission at any time.

Signed by Patient: ……..…… DOB: …..…../……..…/……...

Print Name: …… Date: ……..

Witness to signature: ……Date: ……

I am the patient's main carer, and I agree that flagging specific requirements information is important to patient care, and I agree on behalf of the patient that a card with the symbol indicated above can be placed on the outside of the patient's hospital medical record: Yes ☐ No ☐

I am the patient's main carer, and I agree that flagging specific requirements information is important to patient care, and I agree on behalf of the patient that a sign with details of the patient's specific requirements can be placed above the patient's bed if the patient is admitted to hospital: Yes ☐ No ☐

Please inform a member of staff if you wish to withdraw your permission at any time.

Signed by Carer/Parent on behalf of patient:…… DOB: …..…/……..…/…….

Print Name: …… Date: ……..

Carers address for copies of correspondence ……

Witness to signature: ……Date: ……

After completion please file in the patient's health record in the Allergies and Special Conditions Section - if permission is withdrawn please cross through form and remove sign from notes/bed.

RECOGNITION OF SPECIFIC REQUIREMENTS

Background

On occasion we will care for patients whose individual needs will require further arrangements to be made to ensure their needs can be addressed.
The Recognition of Specific Requirements form allows us to highlight these needs visually either through a card on the medical record and/or a sign placed above the bed. Permission must be sought prior to using any of these visual triggers.

Scope

The group of patients whose needs may be met in this way will include the following disabilities:
Sensory, Physical, Mental Health, Hidden Disabilities, Learning Disability

Responsibility

Permission must be sought during the following encounters with patients: Outpatient, Pre-assessment, Inpatient (both emergency and elective). It is the responsibility of the Practitioner who is most directly involved with the patient (or their carer) to ensure that patients are given the option of having their specific requirements flagged.
If patients agree to their requirement being flagged the procedure below must be followed:

1. Specific Requirement discussed and form given
2. Ensure form is signed
3. Ensure form is filed in the notes in the Allergies & Special Conditions Section
4. Where an ICP is in use the form will remain within the ICP until Discharge, it should then be removed from the ICP and filed in the Allergies & Special Condition section
5. Tick the appropriate boxes on the ICP
6. Place a special requirements card in the plastic message carrier the front of the case notes and annotate accordingly on the inside leaf. Also place sign above bed during inpatient/daycase stays.

The flagging of Specific Requirements must be discussed and agreed with the patient or carer/parent at each subsequent admission/outpatient episode. If the patient withdraws their permission, the specific requirements card must be removed from the notes, the sign above the bed must be removed and a line drawn through the permission form.
.

PATIENT PROFILE

(Please ensure you refer to 'Guidelines for Completion of Patient Profiles')

NAME: **ADDRESS:** **TEL NO:** **PREFERRED NAME**	**HOSPITAL NO.** **NHS NO.** **D.O.B.**	**PP DECLINED** (please tick box) ☐ *You have been offered a Patient Profile but have refused one at this time*

Communication ***Carer has been granted permission to be contacted regarding appointments or receive copies of letters YES/NO***

Mobility

Personal Hygiene

Eating and Drinking

Continence

Sleep Pattern

Favourite Objects

Risks

Behaviour – ***including reaction to pain***

Medical Conditions – ***including known allergies***

Administration of Medication

***Signature of Next of Kin / Main Carer/Person completing Patient Profile*: ……..…….**

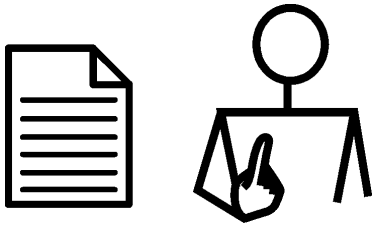
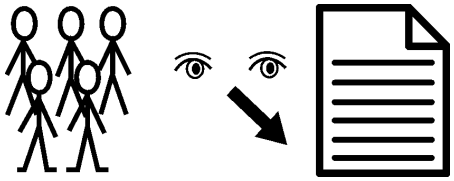
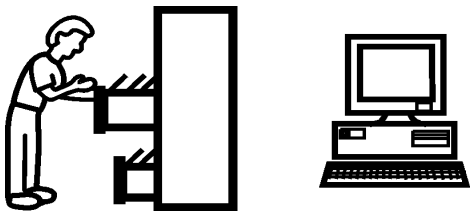
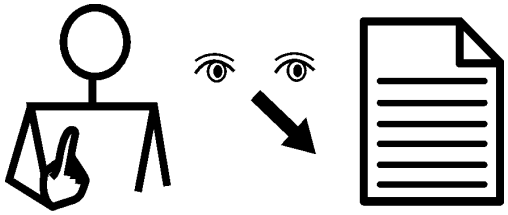
Tel No:……..Print Name……

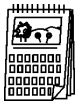
Address……

Date Profile Completed: …… Completed by and typed on behalf of……
Original signed copy kept on Community File

Should you require any further information contact Dementia Specialist Nurse (TORBAY HOSPITAL) on 01803 655859 for advice

Your Consent to Share Information

	**This form is about you**
	**People who help you can see it**
	**A copy will be kept** *in a filing cabinet* *and* *in a computer*
	**You can ask to see what is in the filing cabinet and the computer**
 **Yes, I Agree** ☑ ☐	 **No, I don't Agree** ☑ ☐

 ***Your Name***		 ***DATE***
 ***Your Signature***		