## Patient information form

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| This form has been completed by *(please tick)*: patient [ ]  relative/carer [ ]  hospital staff [ ]  |
| **Patient name:** Click or tap here to enter text. |
| What do you/ the patient prefer to be called? Click or tap here to enter text. |
| **Date of birth**: Click or tap to enter a date. |
| **Address:** Click or tap here to enter text. |
| **Name(s) of friend/relative/carer and relationship(s) to patient:** Click or tap here to enter text. |
| **Contact telephone number(s):** Click or tap here to enter text. |
| Is there someone who could be at home with you/the patient: |
| During the day? | Yes [ ]  No [ ]  | Overnight? | Yes [ ]  No [ ]  |
| Do you/ the patient have any extra help, e.g. help from friends or relatives? | Yes [ ]  No [ ]  |
| If Yes, who helps? Click or tap here to enter text. |
| What do they help with? *(Please tick all that apply):* |
| Washing and dressing  |[ ]  Preparing meals |[ ]  Helping with medication |[ ]
| Shopping |[ ]  Housework |[ ]  Other |[ ]
| If Other, please say what: Click or tap here to enter text. |
| Do you/the patient have any formal help, e.g. alarm cord, home care, meals on wheels, respite care, day centres, or live in a sheltered accommodation/residential/nursing home? Yes [ ]  No [ ]  |
| If Yes, what help is given? Please give contact details for this help if you know them (organisation name and phone number): Click or tap here to enter text. |
| Do you/ the patient have any medical problems or allergies? Yes [ ]  No [ ]  |
| If Yes, please list them: Click or tap here to enter text. |
| What regular medication do you/they take? Click or tap here to enter text. |
| Do you/ the patient need glasses, a hearing aid or wear dentures? Click or tap here to enter text. |
| Do you/the patient have problems with your memory that make day-to-day life more difficult? | Yes [ ]  No [ ]  |
| If Yes, how long have you/they had this problem? Click or tap here to enter text. |
| If Yes, is this problem getting worse? | Yes [ ]  No [ ]  |
| If Yes, has the forgetfulness or confusion suddenly got worse recently? | Yes [ ]  No [ ]  |
| Have you/the patient had any falls in the last year? | Yes [ ]  No [ ]  |
| If Yes, how many falls in the last year? Click or tap here to enter text.If Yes, have there been any blackouts or loss of consciousness? Yes [ ]  No [ ] If Yes, who would normally pick you/them up after a fall? Click or tap here to enter text.Have there been any injuries? If so, what? Click or tap here to enter text.Do you/the patient use any walking aids, such as sticks or Zimmer frame? Yes [ ]  No [ ]  How well are you/they able to get around outside? Click or tap here to enter text.How well are you/they able to move about indoors? Click or tap here to enter text. |
| Do you/the patient have any problems with passing urine, like going to the toilet very often, finding it hard to go, or leaking urine? | Yes [ ]  No [ ]  |
| If Yes, what problems do you/they have? Click or tap here to enter text. |
| Do you/the patient have any problems with constipation or diarrhoea, or other bowel problems? | Yes [ ]  No [ ]  |
| If Yes, what problems do you/they have? Click or tap here to enter text. |
| Have you/the patient made any legal requests? | Yes [ ]  No [ ]  |
| - A Living Will?  | Yes [ ]  No [ ]  |
| - A Lasting Power of Attorney, either financial or medical?  | Yes [ ]  No [ ]  |
| If you/they do have a Lasting Power of Attorney, who has this for you/them? Click or tap here to enter text. |
| Do you/the patient: Drink alcohol? Yes [ ]  No [ ]  Smoke? Yes [ ]  No [ ]  |
| If Yes, how much do you/they drink or smoke per week, on average? Click or tap here to enter text. |
| Is there anything else that it would be useful to know about you/the patient? Click or tap here to enter text. |

*Information About Me is based on research by NIHR Applied Research Collaboration West (NIHR ARC West)*