## 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)*