MacIntyre
Wellbeing for Life
Keep Going ....Don't Stop!

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Attach Photograph Here

Accident & Emergency Grab Sheet

Please Keep Updated in Case of Emergency Admission to Hospital

THIS IS REALLY IMPORTANT DURING THE COVID-19 PANDEMIC

I have a Learning Disability and/or Autism.

- The Human Rights Act means that staff in the NHS must respect and protect my human rights when making decisions about my care even in the time of the Covid-19.
- Decisions about treatment should be made on an individual basis and in consultation with families taking into account my usual health. Decisions about my treatment and resuscitation should not be made based on my learning disability or autism or the Clinical Frailty Scale.
- All decisions must be made in accordance with principles of the Mental Capacity Act.

Full name:

Preferred Name:

Date of Birth:
Address:

Tel no:

Emergency contact:

Relationship to person:

Contact No:

GP Name:

GP Address:

GP Tel No:

NHS No:

Other
(Relevant/ Next of kin if different from emergency contact):

Medical History/Pre-existing medical conditions:
I have/previously had the following breathing problems (e.g. asthma/breathing infections/surgeries compromising airways):

(e.g. Epilepsy, Diabetes, high blood pressure) If epilepsy, describe type of seizure, I have a diagnosis of…

Regular medication:
Is the person on regular medication? Y / N

If yes, take along medicine profile/ MAR chart

How medication is taken:

Known allergies (including medication):

Mental Capacity (please state if you are already aware of areas where the person will need support in decision making, or if a DNACPR/ADRT is already in place).

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Things that make me anxious, (e.g. needles, BP cuff, white coats, noise):	**How to help me feel safe and calm about my anxieties:**

How to communicate with me:

How I usually express pain and distress (e.g. shouting; crying; grinding teeth):

Social Circumstance (e.g. lives alone independently, with carers visiting, in residential home, include how many times carers visit and how they access their building day and night, i.e. key etc.):

Additional health needs, e.g. please specify additional equipment required to support me:
Hearing impairment:
Vision impairment:
Other Sensory impairment: (e.g. touch, taste, smell)
Mobility:
Wheelchair user:
Uses hoist/any other mobility aids:

Special dietary needs (e.g. diabetic, gluten free, soft foods, risk of choking, specialist equipment needed):
Eating:

Drinking:

Likes (e.g. quiet room, personal item/ possession):	**Dislikes** (e.g. certain foods or colours etc):

Don't Forget (e.g. Baseline Health Assessment, Medication Profile, MAR Chart, Communication Profile, Support Plan, PBS documents):

Form Completed By: **Date:**

Next Review Date*:
(*Add to Risk Assessment Schedule to be included in Annual Review/when something changes)

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