**[NAME OF PRACTICE]**

**[PRACTICE ADDRESS]**

**[PRACTICE TELEPHONE NUMBER]**

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| **PERSONALISED CARE PLAN** |
| **PATIENT INFORMATION** |
| Patient name:  |  Title:  | NHS Number:  |
| Date of birth: / / |
| Address: |  |
|  | Post code: |
| Is the patient a nursing or care home resident: YES / NO |
| Contact details: | Key safe door access code: |
| Named accountable GP: | Care coordinator (if appropriate): |
| Other named professionals (e.g. care coordinator, other healthcare professionals or social worker) involved in patient's care, if appropriate (include contact details where possible): |
| Has information been shared on the patient’s behalf?: YES / NO If YES, by whom:(only applicable where the patient does not have the capacity to make this decision)Patient (or other allowed individual) consent to share information: * with other healthcare professionals involved in the patient's care, e.g. carer, OOH etc:

YES / NO* with the multi-disciplinary team:

YES / NO |
| **NEXT OF KIN / CARER / RESPONSIBLE ADULTS INFORMATION** |
| Name:  | Title:  |
| Address (if different from above): |
|  | Post code: |
| Contact details: Relationship: |
| Additional emergency contact (if appropriate):Name: Contact details: Relationship: |
| **PATIENTS MEDICAL INFORMATION** |
| Relevant conditions, diagnosis and latest test results:Significant past medical history: |
| Current medication:Date of planned review of medications: |
| Allergies: |
| **KEY ACTION POINTS** |
| For example: guidance on intervention / deterioration, unmet need to support patient (specify), agreed plan in emergency (ICE)/ useful situation etc.  |
| **OTHER RELEVANT INFORMATION (if appropriate)** |
| Preferred place of care :Other support services e.g. local authority support, housingIdentification of whether the person is themselves a carer (formal or informal) for another person  |
| Anticipatory care plan agreed: YES / NO/ N/A | Anticipatory drugs supplied: YES / NO/ N/A |
| Emergency care and treatment discussed: YES / NO  | If yes, please specify outcome:e.g.: cardiopulmonary resuscitation – has the patient agreed a DNR or what treatment should be given if seizures last longer than x do y etc.  |
| Date of assessment: / / | Date of review(s): |
|  Any special communication considerations (e.g. patient is deaf or language communication differences): |
| Any special physical or medical considerations (e.g. specific postural or support needs or information about medical condition - patient needs at least x mgs of drug before it works etc): |
| **SIGNATORIES (if appropriate and / or possible)** |
| Patient signature: Date:Carer (if applicable) signature: Date:Named accountable GP signature: Date:Care Coordinator signature (if applicable): Date: |