**[NAME OF PRACTICE]**

**[PRACTICE ADDRESS]**

**[PRACTICE TELEPHONE NUMBER]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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, housing  Identification 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: | | | | |