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| **Getting ready for your Annual Health Check**  Annual Health Checks are:  To help you stay well and healthy | |
| **About having an Annual Health Check – Easy Read Guide**  <https://www.mencap.org.uk/sites/default/files/2016-06/Annual_health_checks_Easy_Read_1.pdf> | |
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| Email | **Email:** |
| C:\Users\jane\Downloads\iPhone (3).pngEmail C:\Users\jane\Downloads\Letter Health Check.png | **Please remind me of appointments by ......** |
| **Summary care records**  If you would like **extra information** on your summary care record about **your health** and what **support,** you need let your Doctor know  **Please circle** | |
| **Easy read resources about Summary Care Records:** <https://www.mencap.org.uk/sites/default/files/2019-05/SCR_AI_Easy_Read_Patient_Leaflet.pdf> | |
|  | **I would like**  extra information on my Summary Care Record |
|  | **I do not want**  extra information on  my Summary Care Record |

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| **Consent to sharing information**  Consent is being asked if you agree to something.  This means saying yes or no.    **Please circle** | | | |
| **Easy read resources about consent:**  <https://www.easyhealth.org.uk/index.php/health-leaflets-and-videos/consent/> | | | |
|  | |  | 1. Consent for electronic record sharing? |
|  | |  | 1. Consent to share data with another Professional? (Someone who works to help you) |
|  | | | |
|  | |  | I am not able to consent to sharing my information. |
|  | |  | It has been agreed that it is in my Best Interest to share information. |
|  | | | |
| **Reasonable Adjustments**  A reasonable adjustment is a change your Doctor needs to make so going to the surgery is easier for you. **Please tick the box’s  for ways we can help you.** | | |

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| Easy Read Info 1 (1) | I need **easy read**  Documents. |  |  |
| I need information in **Braille** |  |  |
| I need information in  **Large print.** |  |  |
| I need an **interpreter**. |  |  |
|  | | | |
| Hoist | I use a **wheelchair** and I  will need a **hoist** if I need  a physical examination. |  |  |
| I may need a **home visit**. |  |  |
|  | | | |
| Waiting Room 1 | I would like to come at **quiet times**, because I find it difficult waiting  for my appointment. |  |  |
| I may need to **wait outside** until you are ready to see me. |  |  |
| **Bright lights** or **loud**  **Noises** may affect me. I may need to sit in a quiet room. |  |  |
|  | | | |

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| Timer 15 Timer 30 | I need **longer Appointments** | |  |  |
|  | I need **support** with medical procedures.  Like having an i**njection**, **blood test** or **blood pressure** test. | |  | Ways you can support me….. |
|  | How I have tolerated these tests in the past…. |
|  | | | | |
|  | My **carer** will support you  to understand my needs. | |  |  |
| I get very **nervous** at  appointments and need  my carer to support me. | |  |  |
| Please tell my carer  about any appointments. | |  |  |
|  | | | | |
| NHS Flag (1) | These are the other **things** that will help me…. | | | |
|  | | | | |
| Timetable 2 | **Your measurements**  This is really important and helpful information | | | |
| GP Height | **Height** |  | | |
| Scales | **Weight** | (putting on weight or losing weight) | | |
| Blood Pressure Happy | **Blood Pressure** |  | | |
| Fingertip Pulse Oximeter | **Other** |  | | |
|  | | | | |
| Please **circle** Yesor No  to **tell** the doctor any **problems** and what is **important** for you | | | | |
| Flu Vaccine Tray | **Flu** | **Yes** | **No** | **Your notes...**  **Writing** |
| Have you had your **nasal spray** or  **flu** vaccine **injection**? |  |  |  |
|  | | | | |
| Walking frame  Elderly Fall 3 | **Mobility**  **moving** | **Yes** | **No** | **Your notes...**  **Writing** |
| Stiffness or difficulty moving |  |  |  |
| Pain when moving |  |  |  |
| Falling or tripping |  |  |  |
| Changes in posture / mobility |  |  |  |
| Swelling or redness in limbs / skin |  |  |  |
| Mobility equipment used |  |  |  |

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| **Unhealthy 1** | | **Being Healthy** | **Yes** | **No** | **Your notes...**  **Writing** |
| Healthy 1 (1) | | **Diet**  Do you eat fruit and vegetables? |  |  |  |
| Winner1 | | **Exercise**  Do you exercise? |  |  | What exercise do you do? |
| Cigarettes Pack | | **Smoking**  Do you smoke? |  |  |  |
| LagerWine | | **Alcohol**  Do you drink alcohol? |  |  | How much alcohol do you drink? |
| Cannabis Joint Drugs white powder (1) | | **Drugs**  Do you take illegal drugs? |  |  |  |
|  | | | | | |
| Condom | | **Sexual Health & Contraception** | **Yes** | **No** | **Your notes...**  **Writing** |
| Do you have sex? |  |  |  |
| Do you use contraception? |  |  |  |
| **Guides to support people with learning disabilities with issues around sex and relationships**  <https://www.choicesupport.org.uk/about-us/what-we-do/supported-loving/supported-loving-toolkit> | | | | | |
|  | | | | | |
| Bowel cancer screening in England | Bowel Cancer UK | | **Bowel Cancer check** | **Yes** | **No** | **Your notes...**  **Writing** |
| Are you aged  60-74? |  |  |  |
| If yes, have you received your bowel test kit? |  |  |  |
| **Bowel Screening an Easy Guide:** <https://www.gov.uk/government/publications/bowel-cancer-screening-easy-guide> | | | | | |
| Gender Female | **Female health checks** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Body breasts f (1) | Do you check  breasts? | |  |  |  |
| Have you seen or felt  changes to your  Breasts? | |  |  |  |
| Have you had Breast screening (age 50+) | |  |  |  |
| When Do I Need to Get a Pap Smear? | Have you had a smear test? | |  |  |  |
| Hot flush (1)Sanitary towel | Change in periods e.g. heavy bleeding in between periods | |  |  |  |
| Painful periods | |  |  |  |
| Vaginal discharge | |  |  |  |
| Menopause symptoms | |  |  |  |
| **Puberty and period in girls with developmental delay**  <https://www.myfamilyourneeds.co.uk/support-child/puberty-and-periods-in-girls-with-developmental-delay/>  **An easy guide to cervical screening**: <https://www.gov.uk/government/publications/cervical-screening-easy-read-guide>  **An easy guide to breast screening:** <https://www.gov.uk/government/publications/breast-screening-information-for-women-with-learning-disabilities>  **Supporting people with learning disabilities to take care of their breasts:**  <https://www.easyhealth.org.uk/wp-content/uploads/2020/02/supporting-peaople-with-learning-disabilities-to-take-care-of-their-breasts.pdf> | | | | | |
| Gender Male | **Male health checks** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Body testicles m | Do you check your  testicles / balls? | |  |  |  |
| Have you seen or felt  changes to your  testicles / balls? | |  |  |  |
| Heart 2 | Have you had your  Abdominal Aortic  Aneurysm or AAA  check? **(Age 65 +)** | |  |  |  |
| **Puberty in boys with developmental delay:**  <https://www.myfamilyourneeds.co.uk/support-child/puberty-in-boys-with-additional-needs/>  **How to look after my balls:**  <https://www.easyhealth.org.uk/wp-content/uploads/2020/03/How-to-look-after-my-balls.pdf>  **Abdominal Aortic Aneurysm or AAA screening:**  <https://www.easyhealth.org.uk/wp-content/uploads/2020/03/Abdominal-Aortic-Aneurysm-AAA-Screening.pdf> | | | | | |
|  | | | | | |
| Body eye f | **Eyes** | | **Yes** | **No** | **Your notes...**  **Writing** |
| When did you have your eyes tested? | |  |  | Date: |
| Do you have any eyesight problems or wear glasses? | |  |  |  |
|  | | | | | |
| Body ear m | **Ears** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Have you noticed any problems or changes to your hearing? | |  |  |  |
| Have you had an ear test? | |  |  | Date: |
|  | | | | | |
| Teeth | **Teeth** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Do you have a dentist? | |  |  |  |
| When was your last visit? | |  | | Date: |
| Do your teeth hurt? | |  |  |  |
| Do your gums bleed? | |  |  |  |
| Do you have a swelling or a lump? | |  |  |  |
| Do you have difficulty eating? | |  |  |  |
|  | | | | | |
| Breathe deep (3) | **Respiratory**  Chest & Breathing | | **Yes** | **No** | **Your notes...**  **Writing** |
| Is it hard to breathe? | |  |  |  |
| Coughing that won’t go away | |  |  |  |
| Chest infections | |  |  |  |
| Coughing up blood | |  |  |  |
| Unusual coloured spit | |  |  |  |
| Wheeze | |  |  |  |
| Hay fever, allergies, asthma | |  |  |  |
|  | | | | | |
| IBS (1) | **Bowels and Poo** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Constipation – hard poo or can’t poo | |  |  |  |
| Watery poo and going too much | |  |  |  |
| Bleeding from your bottom | |  |  |  |
| Difficulty getting to the toilet on time | |  |  |  |
| Changes in having a poo | |  |  |  |
| Indigestion | |  |  |  |
| **Information and easy read guides about constipation:**  <https://www.england.nhs.uk/publication/constipation-learning-disability-resources/> | | | | | |
| Need a wee (1) | **Urine / wee** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Pain when you wee? | |  |  |  |
| Have you had a urine infection? | |  |  |  |
| Wee more often? | |  |  |  |
| Do you find it difficult to start weeing? | |  |  |  |
| Start and stop when  weeing? | |  |  |  |
| Blood in your wee | |  |  |  |
| Difficulty getting to the toilet on time? | |  |  |  |
|  | | | | | |
| Brain Seizure | **Epilepsy**  **Brain** | | **Yes** | **No** | **Your notes...**  **Writing** |
| **If you have epilepsy please answer these questions**  **Please bring your seizure chart with you, if you have one.** | | | | |
| How many seizures per month? | |  |  |  |
| Any changes to seizures? | |  |  |  |
| Are you under the care of a specialist (neurologist)? | |  |  | When did you last see them? |
| Do you take your epilepsy medication when you should? | |  |  |  |
| Do you have any side effects i.e. feeling dizzy, sick, irritable or have blurred version? | |  |  |  |
|  | | | | | |
| Heart 2 | **Heart** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Is it difficult to breath? | |  |  |  |
| Do you have chest pain when exercising? | |  |  |  |
| Any swelling to the ankles, hands or body? | |  |  |  |
|  | | | | | |
| Diabetes test2 | **Diabetes** | | **Yes** | **No** | **Your notes...**  **Writing** |
| **If you have diabetes please answer these questions**  Please bring your blood sugar charts if you have them | | | | |
| Do you test your blood sugar regularly? | |  |  |  |
| Do you have any problems with your eye sight? | |  |  |  |
| Have you been for your diabetic eye  test? | |  |  |  |
| Body feet f | **Feet** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Have you been to a  podiatrist or foot specialist? | |  |  | If yes when did you go? |
| If no, who cuts your nails? | |  |  |  |
| Do you have any pain in your feet? | |  |  |  |
|  | | | | | |
| Headache | **Pain** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Do you have any pain? | |  |  |  |
| Does your pain medicine help? | |  |  |  |
|  | | | | | |
|  | **Skin** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Dry or Itchy Skin | |  |  |  |
| Changes to moles | |  |  |  |
| Cold Sores | |  |  |  |
| Sores or open wounds | |  |  |  |
| Changes to the colour of your skin? | |  |  |  |
|  | | | | | |
| Stress | **Mental Health** | | **Yes** | **No** | **Your notes...**  **Writing** |
| Feeling low, sad or unhappy? | |  |  |  |
| Feeling worried, frightened or anxious? | |  |  |  |
| Do you feel like crying? | |  |  |  |
| Do you feel like you can’t cope? | |  |  |  |
| Do you feel irritable, aggressive or violent? | |  |  |  |
| Think about hurting yourself or actually hurt yourself? | |  |  |  |
| Sleeping too much or not sleeping | |  |  |  |
| Do you hear voices or see things? | |  |  |  |
| Worries about your memory? or confusion? | |  |  |  |
| Have you spoken to someone about  how you feel? | |  |  |  |
| **Mental Health and Learning Disabilities – easy read leaflets and guides:**  [**https://www.rcpsych.ac.uk/mental-health/problems-disorders/learning-disabilities**](https://www.rcpsych.ac.uk/mental-health/problems-disorders/learning-disabilities) | | | | | |
|  | **Medication Review**  Your Doctor will talk to you about your medicines and  look at whether your medicines are right for you. | | | | |
| Do you have any **concerns** or **questions** about your medication? | | |  |  |  |
| **Guide for supporting a person to a GP appointment to talk about psychotropic medication** <https://www.vodg.org.uk/wp-content/uploads/2017-VODG-Preparing-to-visit-a-doctor-to-talk-about-psychotropic-medication.pdf> | | | | | |

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| 394AA36 | **End of Life Care** | | | | |
| Do you have a ‘**DNAR’** (Do Not Attempt  Resuscitation) or **‘ReSPECT’** (Recommended Summary Plan for Emergency Care and Treatment)  Form? | | |  | |  |
| Any **concerns** or **questions** about these documents? | | |  | |  |
| **RESPECT information for patients and carers:**  <https://www.resus.org.uk/respect/patients-and-carers/> | | | | | |
|  | | | | | |
|  | **My Care Passport**  Help hospital staff understand how to help you | | |  | |
| Do you have a My Care Passport? | |  |  | |  |
| Question 4 | **Do you have any Questions?**  Is there anything you want the Doctor or Nurse to know? | | | | |
|  | | | | | |
| Health Action Plan (2) | **Health Action Plan**  At the end of your Annual Health Check **you** should **get** a copy of your **Health Action Plan**. | | | | |
|  | | | | | |
| Assessment | **Thank you** for filling out this form  Please **bring it** to the Annual Health Check  **Meeting**. | | | | |
|  | | | | | |
| Health Action Plan (2) | **My Health Action Plan**  Notes | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **What I will do?** | **When I will do it?** | **Who will help me?** | |  | | --- | | **I have done it!** | |
|  |  |  |  |
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