

# My vital information for delivering healthcare

## I have a learning disability

Name

I like to  
be called

Pronouns I like to use  
(He/She/They):

Date of Birth:

Address:

NHS No:

Ethnicity:

NI Number:

Religion:

Languages I understand (including Makaton):

GP Name and Address:

Is your next of kin actively involved in your life? ☐ YES ☐ NO

Next of Kin Name, Relationship and Contact Details:

Other Key Person's Name and Contact Details:

Who they are to me:

Continued Overleaf

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I give permission for health professionals to talk to these people about me:

☐ YES    ☐ NO    ☐ Unable to give permission but considered in their Best Interest

Details why:

Do you have an active ReSPECT/DNACPR in place? See guide. ☐ YES ☐ NO

Details:

Spiritual/cultural needs:

Are you allowed free prescriptions? See guide. ☐ YES ☐ NO

If YES detail the reason.

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I believe I am allergic to these drugs:

I believe I am allergic to these foods:

### Lasting power of attorney for health & welfare/personal welfare deputyship

Does anyone have lasting power of attorney/deputyship for your health needs?

Circle or highlight the answer below:

☐ YES   ☐ NO

If **YES** store a copy of the lasting power of attorney/deputyship with this document and record here the name & contact details of your attorney/deputy:

Name

Telephone  
number:

Address:

Name

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Date of birth:

Do you have a prescription prepayment certificate? ☐ YES ☒ NO

I believe I am allergic to these drugs:

I believe I am allergic to these foods:

### Lasting power of attorney for health & welfare/personal welfare deputyship

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## The nature of my learning disability

Brief overview of your diagnosis and/or how the learning disability impacts you in everyday life. Please highlight any essential information e.g. triggers or indicators that you may become so anxious you could harm yourself or others.

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## Vaccines

Annual Flu Vaccine dates						
Was Flu given via nasal spray <input type="checkbox"/> YES <input type="checkbox"/> NO						
Covid-19 Vaccine dates						
Covid-19 Booster Vaccine date						
HPV Vaccine dates						
Childhood Vaccines received e.g. Diphtheria, Polio, Measles, Mumps, Rubella etc <input type="checkbox"/> YES <input type="checkbox"/> NO						
Pneumococcal Vaccine dates						
Last Tetanus date						

Continued Overleaf

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**The reasonable adjustments I need** to be help me accept health appointments, investigations, and treatment (**in line with the Equality Act 2010**)

**i** Think about **T.E.A.C.H** – Time, Environment, Solution finding attitude, Communication and Help – see guidance notes

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**The communication needs I have** to be able to accept Health appointments, investigations, and treatment (in line with the **Accessible Information Standard 2016**)

**i** See guidance notes – make sure the GP practice and social care (if involved with you) are aware of these communication requirements and have them **flagged** on their system.

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## Top tips on supporting me within health settings

**i** Write information that would help someone who had never met you before to know how to help you to make you feel at ease and reduce anxiety if you were in a strange health environment.

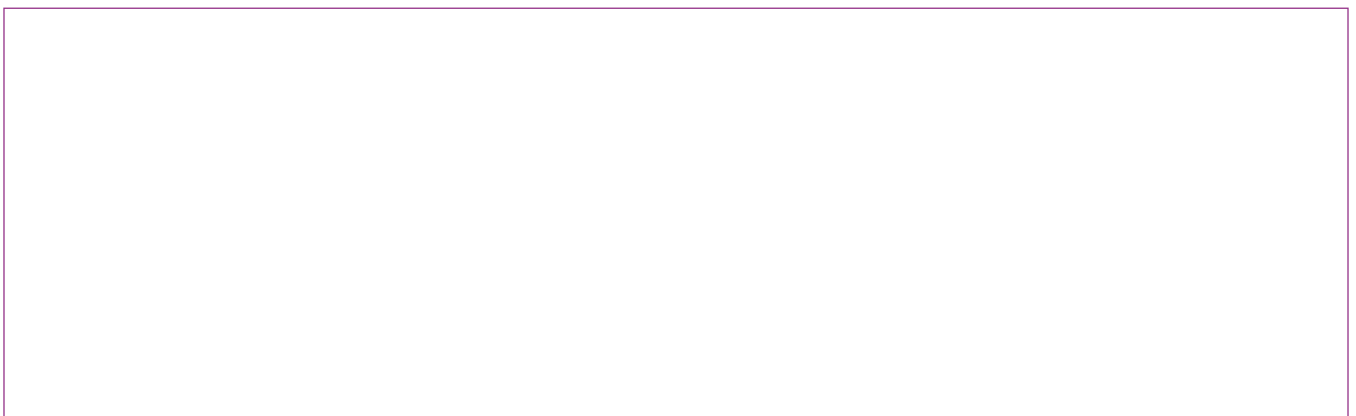
### Helping you to understand me



### Helping me to understand you



### Eating and Drinking (use a highlighter pen to emphasise any swallowing difficulties)



Continued Overleaf



**Name**

**I like to  
be called**

**Date of birth:**

**How I use the toilet, wash, and dress**

**Taking medication**

**Sexual and personal health**

**Moving around, mobility and wheelchair transfers**

Name

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Date of birth:

## Known barriers, fears, phobias to health investigations and/or treatment and ways to overcome

**i** Please use additional pages for specific reasonable adjustments to support blood taking and needle phobias

☐ I am not happy having blood tests and/or injections, please see 'reluctance to accept blood taking or injections' page for information on how to support me.

## Any other equipment I need and what they are used for

**i** Include information about hearing aids, dentures, glasses etc and any top tips on how to help me use them

## My signs of being unwell or in pain

**i** What I am like when I am well (this is how I behave, communicate, and move).  
If you have a '**Me on my Best Day**' video please make a note here

Continued Overleaf

**Name**

**I like to  
be called**

**Date of birth:**

**i** What I am like when I am unwell or in pain (this is how I behave, communicate, and move):

**Summary of any long-term conditions that I have**

**Summary of any long-term medication that I take**

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## My baseline health measurements

**i** This information is to be updated annually with the Annual Health Check. Please use additional recording pages if these are being measured more frequently (i.e., weight management)

Date					
Weight					
BMI					
BMI Classification					
Blood pressure					
Pulse					
Oxygen Saturation					
Respiration					
Height					
MUST Score					

## If I were to become very unwell suddenly, these are the things I need

**i** See guidance notes to see who also may require additional information

☐ I have an End of Life plan in place

*See guidance to establish who should have an advance care plan.*

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## Health Professionals Involved relating to my health conditions (historically or currently)

Name and role:

Contact details:

Nature of involvement:

Date involved from/until:

Name and role:

Contact details:

Nature of involvement:

Date involved from/until:

Name and role:

Contact details:

Nature of involvement:

Date involved from/until:

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## Key additional people involved in my health and wellbeing

**i** This is social workers, key care support etc that have not been mentioned on previous page

**Name and role:**

**Contact details:**

**What they do to help me:**

**Name and role:**

**Contact details:**

**What they do to help me:**

**Name and role:**

**Contact details:**

**What they do to help me:**

Name

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Date of birth:

## Additional health conditions/health intervention support

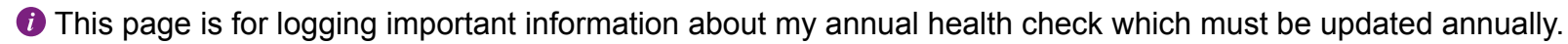
**i** Health professionals use this page to summarise your specific medical interventions and the reasonable adjustments you use to enable this.

<b>Area of Health:</b> (e.g Epilepsy/Physiotherapy for respiratory/SALT)	
<b>Health professionals involved, names and contact details:</b>	
<b>Start date/timeframe of intervention:</b>	
<b>Current intervention/ health plan:</b> (if the plan relates to physical support e.g sleep systems or positioning then consider adding photos to help demonstrate correct positions and equipment)	
<b>Medication/medication plan</b> (if applicable):	

**Top tips/reasonable adjustments to support the delivery of this plan (for use should a different clinician be required to pick up this role):**

**i** (See guidance, remember to consider all areas of TEACH and whether adding photos will aid someone to support this person in your absence.)

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[illegible]



[illegible]

[illegible]

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## Reluctance to accept blood taking or injections



Historically, have you had the capacity to understand the reasons bloods need to be taken/injections need to be given, and the risks to your health of not having them?:

**i** (Please give some examples from the past of the level of understanding you had for the REASONS for a blood test/injection and risks of not having it.)

If you have historically ***had capacity*** to decide to have blood tests/injections, what were the best ways to support you to have these?:

**i** (e.g. playing music, distraction, specific venue, specific person, shielding so you can't see, gentle holding or sedation etc)

If historically you ***did not have capacity*** and a ***best interest*** decision was made on your behalf with injections/blood tests, what were the least restrictive methods for achieving these?:

**i** (e.g. playing music, distraction, specific venue, specific person, shielding so you can't see, gentle holding or sedation etc)

# Mental Capacity to understand Data Protection Relating to My Purple Folder

This Purple Folder is a record of the owner's health and, as such, will contain confidential and personal information. It is important that the person who owns it understands this and is supported to maintain and store this folder safely.

If the owner does not have the capacity to understand the information stored and the data protection risks then the people that support them will need to make a best interest decision to hold, maintain and safe keep this folder.

## Mental Capacity Assessment

**Does the owner have the capacity to understand the following points?**

- This folder holds important health information about them, meaning anyone they give this folder can read this information
- It should only be health professionals and the people that support them who read and write in this folder
- The good thing about the folder is it will help health professionals know all the health treatments they are having and will help them know what helps the person to accept health treatment
- If they think some of their health problems are very private and they don't want other health professionals knowing about them, they can ask the health professional NOT to write about it in their folder.

**Could the owner understand and remember all this information about the Purple Folder?**

**Yes / No** (please delete as appropriate)

Please detail how they communicated to indicate this in the box below:

**If the answer above is no**, and they are not likely to be able to gain capacity to understand with more time then the people who support them need to make a **Best Interest Decision**.

- Does this person's learning disability mean they have barriers to receiving good healthcare?
- Could the Purple Folder help health professionals support the person and reduce the risk of delays in treatment and/or diagnosis? For example, this person may need alternative means of communication, have a reluctance to accept health interventions, difficulties understanding the risks and benefits of investigations/treatments, reasonable adjustment requirements and additional support needs.

***If yes, then a Purple Folder will be in their best interest to reduce the known risk of delays in health care diagnosis for people with learning disabilities.***

## Data Protection

The risks associated with data breach need to be considered and a plan agreed.

1. Where will the file be stored that will mitigate the risk of a data breach?

2. What steps will be taken when going out with the folder to ensure it is kept safely and returned?

3. If a health intervention of a personal/sensitive nature happens, the people who support the person and the health professional involved should discuss whether it is in the person's best interest for this information to be recorded in the Purple Folder (weighing up the element of whether other health professionals would 'need to know').

What has been done to ensure all who may support the owner to health appointments understands this?

**Owner's signature (if they have capacity):**

**Completed by:**

**Role/relationship to the owner:**

**Date:**

***The Purple Folder and this Mental Capacity Assessment should be reviewed annually at the time of the owners Annual Health Check.***