

NAME:
NHS NUMBER:
DATE VERSION COMPLETED/UPDATED (DD/MM/YYYY):



PERSONAL CARE PLAN FOR POLIO SURVIVORS

CONSENT: I, or my trusted representative, agree to the sharing of my care and support plan with relevant individuals, involved in my care, including my GP

Name: _____ Signed: _____ Date (DD/MM/YYYY): _____

PATIENT OVERVIEW

My date of birth (DD/MM/YYYY): _____

My address: _____

Postcode: _____

My phone or mobile number: _____ Email: _____

My GP's name and address: _____

Postcode: _____

My GP's phone number: _____ Email: _____

My GP's name (if you have one): _____

How I would like to be contacted/receive information (tick all that apply and ensure details are above):

- Post
- Email
- Text
- Phone

Name and contact details of next of kin/emergency contact: _____

Who I live with (tick all that are relevant):

- I live alone
- Spouse/partner
- Children
- Other relatives
- Friends
- Live-in carer(s)
- Other (please specify) _____

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My support/care system includes (tick all that are relevant):

- My partner can support/care for me
- My family and friends can support/care for me
- I don't currently need any support/care
- I have a carer (number of hours a week care is provided): _____
- I have no one who can support/care for me
- I am a carer for someone else
- Other (please specify): _____

My current occupation or daily role is (tick all that are relevant):

- Working
- Studying
- Volunteering
- Caregiving
- Retired
- Unemployed
- Unable to work
- Other (please specify) _____

Here is my current health condition, and what I think is important for you to know:

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POLIO HISTORY

(Select the parts of your body affected by polio at each stage and provide details below including operations)

ACUTE POLIO AND REHABILITATION STAGE

- HOW OLD WERE YOU?:
- WHICH PARTS OF YOUR BODY WERE AFFECTED?

PARTS OF BODY AFFECTED ON MY LEFT SIDE (tick all that apply):	PARTS OF BODY AFFECTED ON MY RIGHT SIDE (tick all that apply):	OTHER PARTS OF BODY AFFECTED (tick all that apply):
<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Throat <input type="checkbox"/> Stomach <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Back <input type="checkbox"/> Lungs <input type="checkbox"/> Bladder/bowel

- PROVIDE DETAILS (INCLUDE RELATED OPERATIONS):

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AT YOUR BEST ABILITY HOW WERE YOU?

- **HOW OLD WERE YOU?:**
- **WHICH PARTS OF YOUR BODY WERE AFFECTED?**

PARTS OF BODY AFFECTED ON MY LEFT SIDE (tick all that apply):	PARTS OF BODY AFFECTED ON MY RIGHT SIDE (tick all that apply):	OTHER PARTS OF BODY AFFECTED (tick all that apply):
<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Throat <input type="checkbox"/> Stomach <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Back <input type="checkbox"/> Lungs <input type="checkbox"/> Bladder/bowel

- **PROVIDE DETAILS (INCLUDE RELATED OPERATIONS):**

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AS NEW PROBLEMS START TO EMERGE

- HOW OLD WERE YOU?:
- WHICH PARTS OF YOUR BODY WERE AFFECTED?

PARTS OF BODY AFFECTED ON MY LEFT SIDE (tick all that apply):	PARTS OF BODY AFFECTED ON MY RIGHT SIDE (tick all that apply):	OTHER PARTS OF BODY AFFECTED (tick all that apply):
<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Throat <input type="checkbox"/> Stomach <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Back <input type="checkbox"/> Lungs <input type="checkbox"/> Bladder/bowel

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HOW ARE YOU NOW?

- **HOW OLD ARE YOU?:**
- **WHICH PARTS OF YOUR BODY WERE AFFECTED?**

PARTS OF BODY AFFECTED ON MY LEFT SIDE (tick all that apply):	PARTS OF BODY AFFECTED ON MY RIGHT SIDE (tick all that apply):	OTHER PARTS OF BODY AFFECTED (tick all that apply):
<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Eye <input type="checkbox"/> Ear <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist/hand <input type="checkbox"/> Leg <input type="checkbox"/> Ankle/foot	<input type="checkbox"/> Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Throat <input type="checkbox"/> Stomach <input type="checkbox"/> Chest <input type="checkbox"/> Pelvis <input type="checkbox"/> Back <input type="checkbox"/> Lungs <input type="checkbox"/> Bladder/bowel

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Common conditions experienced by polio survivors:

CONDITION	AFFECTS ME? (Select which applies)
Cardiovascular disease	
Respiratory issues, or lung problems	
Diabetes	
Osteoporosis	
Osteopenia	
Arthritis	
Carpal Tunnel Syndrome	
Nerve entrapment	
Stroke	
Obesity	

My medication

NAME OF MEDICATION	DOSE (IF KNOWN)	WHAT PRESCRIBED FOR

Other relevant polio-related medical history that would be helpful to record

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MY SYMPTOMS AND HOW THEY AFFECT ME

(Rate if/how symptoms affect you (select best option) on your best day, worst day and overall life)

Symptom	ARE YOU AFFECTED (Y/N)?	Least severe day	Most severe day	My overall life
Fatigue				
Weakness				
Pain				
Muscle fatigue				
Difficulty getting to sleep				
Disturbed sleep				
Unrefreshing sleep				
Breathing issues				
Swallowing difficulties				
Spinal deformities (e.g. scoliosis)				
Joint deformities				
Bowel or urinary functional problems				
Poor temperature control				
Increased frequency of falls or near misses				
Anxiety or stress				
Mobility problems				
Problems standing				
Other:				
Other:				
Other:				

Things I used to like doing but am finding harder because of my symptoms:

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Help needed for daily activities (enter N/A if the activity does not apply to you):

DAILY ACTIVITY	WHAT HELP IS NEEDED (FROM A HELPER AND/OR EQUIPMENT)?
Getting up	
Washing and bathing	
Dressing and undressing	
Preparing a cooked meal	
Eating and drinking	
Managing my medication	
Managing toilet needs or incontinence	
Moving around	
Using stairs	
Getting in and out of a chair	
Other:	

Do you use any assistive devices or mobility aids? (tick all that are appropriate)

ASSISTIVE DEVICES/MOBILITY AIDS	HOW LONG HAVE YOU BEEN USING IT?
Manual/electric wheelchair	
Mobility scooter	
Walking frame/rollator	
Walking stick(s) or crutches	
Ankle-foot orthoses (AFOs)	
Knee-ankle-foot orthoses (KAFOs)	
Back brace/spinal jacket	
Custom footwear/shoe modification	
Bed/chair lift	
Stairlift	
Footwear (special shoes, shoe lift, insoles etc)	
Hoist	
Respiratory equipment (e.g. C-PAP/B-PAP machine)	
Other (please specify)	

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HEALTH AND WELLBEING

My health and wellbeing goals and aspirations (Select the best options)

MY GOAL	DATE REVIEWED (DD/MM/YYYY)	WHAT WOULD HELP ACHIEVE THIS GOAL	DIFFICULT TO ACHIEVE	PROGRESS TO GOAL (DATED) (DD/MM/YYYY)

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List of tests done and advice (Current and historic)

MEDICAL AREA (E.G PAIN, RESPIRATORY)	TREATMENT / TESTS (LIST)	DATE (DD/MM/YYYY) (OR YEAR IF NOT KNOWN)	CURRENT ACTION PLAN AND ADVICE

SUPPORT SERVICES

Services that are now supporting me:
Financial/benefits support you receive (e.g. PIP of ADP, Pension Credit, Attendance Allowance):

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Services that have supported me in the past:

ANY OTHER USEFUL NOTES/INFORMATION YOU WOULD LIKE RECORDED

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SUMMARY OF DISCUSSIONS WITH CLINICIAN/HEALTHCARE PROFESSIONAL AND NEXT STEPS:

DATE (DD/MM/YYYY)	DISCUSSIONS AND NEXT STEPS

SAVE AND PRINT