

NAME:  
NHS NUMBER:  
DATE 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 surgery's name and address: \_\_\_\_\_

Postcode: \_\_\_\_\_

My GP surgery'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):**

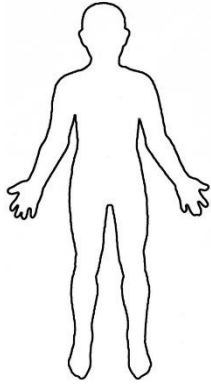
- Working
- Studying
- Volunteering
- Caregiving
- Retired
- Unemployed
- Unable to work
- Other (please specify) \_\_\_\_\_

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

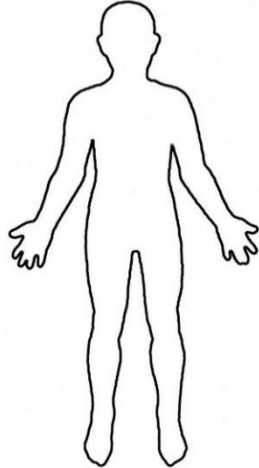
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**POLIO HISTORY**

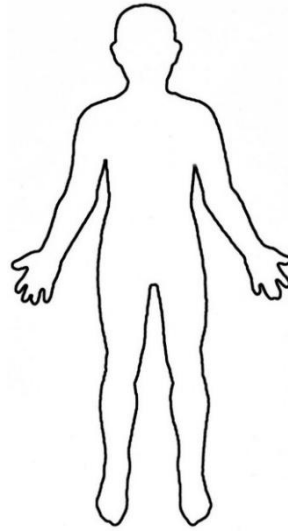
(Circle or tick parts of body affected by polio at each stage and provide details below including related operations)



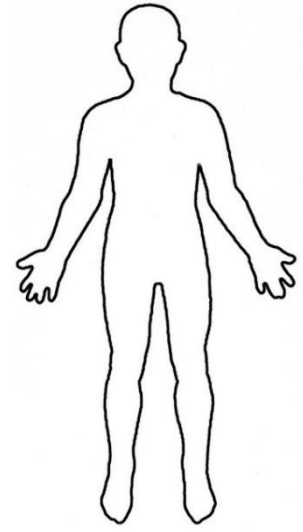
RIGHT SIDE LEFT SIDE



RIGHT SIDE LEFT SIDE



RIGHT SIDE LEFT SIDE



RIGHT SIDE LEFT SIDE

ACUTE POLIO AND REHABILITATION	AT YOUR BEST ABILITY HOW WERE YOU?	BECAME AWARE OF NEW PROBLEM(S)	HOW ARE YOU NOW?
AT AGE:	AT AGE:	AT AGE:	AGE:

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**Common conditions experienced by polio survivors:**

CONDITION	AFFECTS ME? (Circle which applies)
Cardiovascular disease	YES / NO / DON'T KNOW / NOT TESTED
Respiratory issues, or lung problems	YES / NO / DON'T KNOW / NOT TESTED
Diabetes	YES / NO / DON'T KNOW / NOT TESTED
Osteoporosis	YES / NO / DON'T KNOW / NOT TESTED
Osteopenia	YES / NO / DON'T KNOW / NOT TESTED
Arthritis	YES / NO / DON'T KNOW / NOT TESTED
Carpal Tunnel Syndrome	YES / NO / DON'T KNOW / NOT TESTED
Nerve entrapment	YES / NO / DON'T KNOW / NOT TESTED
Stroke	YES / NO / DON'T KNOW / NOT TESTED
Obesity	YES / NO / DON'T KNOW / NOT TESTED

**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 (circle or tick the best option) on your best day, worst day and overall life)

SYMPTOM	ARE YOU AFFECTED?	LEAST SEVERE DAY	MOST SEVERE DAY	MY OVERALL LIFE
Fatigue	YES/NO			
Weakness	YES/NO			
Pain	YES/NO			
Muscle fatigue	YES/NO			
Difficulty getting to sleep	YES/NO			
Disturbed sleep	YES/NO			
Unrefreshing sleep	YES/NO			
Breathing issues	YES/NO			
Swallowing difficulties	YES/NO			
Spinal deformities (e.g. scoliosis)	YES/NO			
Joint deformities	YES/NO			
Bowel or urinary functional problems	YES/NO			
Poor temperature control	YES/NO			
Increased frequency of falls or near misses	YES/NO			
Anxiety or stress	YES/NO			
Mobility problems	YES/NO			
Problems standing	YES/NO			
Other:	YES/NO			
	YES/NO			
	YES/NO			

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** (Circle the best options)

MY GOAL	DATE REVIEWED	WHAT WOULD HELP ACHIEVE THIS GOAL	DIFFICULT TO ACHIEVE	PROGRESS TO GOAL (DATED)
			Not / Slightly / Moderately / Extremely	
			Not / Slightly / Moderately / Extremely	
			Not / Slightly / Moderately / Extremely	
			Not / Slightly / Moderately / Extremely	

**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



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**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