**Summary**

**Section 1 My Personal Information and Plans**

Essential personal information, personal care plan preferences and information about other actions an individual may wish to consider for him/herself. It includes contact details of people and organisations the individual may wish to contact.

**Section 2 My Appointments and Communication Logs**

Personal communication records and appointments made by the individual.

**Section 3 My Personal Health and Social Care Information and Plans**

Information pertaining to ‘my health and social care’ including ‘my single comprehensive Care Plan’, health documents and plans e.g. assessments, test results, operation and treatment notes, medicines, social care plans and documents including assessments, services, notes, letters about me and any other contents as appropriate e.g. Optician, Dentist, Ophthalmologist.

**Section 4 Local, National and Community Information**

Other personal Information you may wish to record e.g. local and national information relevant to you including laws, rights, strategies, action plans, guidance, community support etc. guidance,

**My Personal Record has four clear sections.**

* Initially each person may only need one section to hold their basic information
* Each section has a suggested list of things to consider from which individuals can choose the activity or action that is right for them.
* Each section could become a separate folder if preferred or needed because of the size of individual contents.
* The suggested contents include a number of suggested documents and actions that you may wish to use. You select the documents you want to use.
* You may wish to use different documents of your choice. This is your choice as long as you record similar information.
* You may choose to add other additional documents as your needs change. It is your choice.
* The only essential document is a summary information sheet about you. You may also wish to complete your personal profile (health and care information) and your preferences for care as these list your core personal information and personal choices.

**Section One My Personal Information and Plans**

1. **My Personal Information Summary and Personal Profile**
   1. **My Personal Information Summary Record (PI)** -important, simple, basic information about me that I need to remember and people may need to know about me

* 1. **My Personal Profile (PP)** - Important personal information about me, including my carer, main contact, allergies, health condition, services, support and any changes I make to the way I take repeat medication - plus any non-prescribed medicines I take/use (see SIO PP guidelines).

**Contacts / information (people may wish to record)**

* 1. **People** - relatives/friends - inform about my illness or end of life
  2. **Organisations** - groups to which I belong - inform about my illness or end of life.
  3. **Health, Care and** - contact information about people and organisations who **Community** support me, arrange my care e.g. GP, Community Nurse,

Hospital, Care Agency, Personal Assistant etc.

* 1. **Household** - information that may be useful e.g. deliveries, stopcocks etc.
  2. **Documents** - informationabout me e.g. driving licence, birth certificates,

passport, blue badge - where they are, passwords etc.

* 1. **Legal** - **i**nformation about my affairs e.g. who holds my Will, my chosen

LPA Attorneys etc.

* 1. **Financial** -information aboutmy Bank Accounts, any investments I have
  2. **Insurances** - insurancesthat I have and hold including private health cover

1. **Personal Planning - Arrangements and Statements**

Suggested personal individual arrangements, activities and statements that may be useful

1. **My Personal Care Plan (My personal preferences for Care)** – important personal choices I have made about my care including my personal support plan, emergency arrangements and long term wishes (see SIO PCP Guidance)
2. **Arrangements I have made** – (see PA Guidance)
   1. **Lasting Power of Attorney (Health and Welfare)**
   2. **Lasting Power of Attorney (Property and Financial Affairs)**
   3. **Last Will and Testament (also see Letter of Wishes)**
   4. **Advance Care Plan**
   5. **Advance Statement**
   6. **Advance Decision or Living Will**
   7. **Letter of Wishes**
   8. **Funeral Arrangements**
   9. **Actions after End of Life & Tell us Once**
   10. **Consent Forms** – personal consent forms as appropriate e.g. UDNACPR (purple form)

**Section Two My Appointments and Communication Logs – optional**

**Use this section when you:**

* **have longer term heath and care conditions**
* **may need to attend lots of appointments**
* **have a number of people coming to your house**
* **may have a lot of treatment you need to have or go to.**

1. **Calendar/Diary** -dates booked

* meetings arranged
* appointments arranged

1. **Communication Log** - Daily messages and/or feedback left in my house and/or in

my file. This could be completed by me, my family and/or by visitors, care workers, other workers

1. **Emergency Card**  -credit card sized piece of card in my bag/wallet with the

contact number of a person to be called if need help.

It is not recommended that you put names and addresses on the card – just your first name and the contact telephone number of the person to call if needed

1. **ICE Number** - an entry in my mobile telephone of the person I wish to be contacted in the case of an emergency about me
2. **Message in a Bottle** - brief record in the fridge door that directs others to where I

keep important information

**Section Three My Personal Health and Social Care Information and Plans**

1. **My Care Plan – health, social care, family, community**

**One single Care Plan for me**

There should be **‘one single care plan’** per person. It should include different sections combined from:

* My Personal Care Plan (My Care Preferences)
* Input from my family & friends,
* Plans prepared with me by/from:
* Adult Services (AS),
* Doctor (GP),
* Community Nurse,
* Hospital,
* Residential/Nursing Home,
* Physiotherapist,
* Occupational Therapist (OT),
* Other providers and professionals or other people who know me.

(This single care plan should take the place of the range/number of different care plans currently prepared for me by professionals (from different organisations) working with me.

1. **Health documents and plans**

* Test results
* Health information
* Assessments
* Notes - letters about me, operation notes, treatment notes (GPs, Health Trusts)
* Private Health Care documents etc.

**Treatment continuing**

e.g. diabetes, pain control, long term conditions etc.

**Medicines**

Repeat medication list from my GP with any changes I make to the way I take it - plus non prescribed medicines I take/use.

1. **Adult Services documents and plans**

Adult Services care plans, assessments, services, notes, letters about me etc.

1. **Other sections as appropriate and preferred e.g.:**

* Optician,
* Dentist,
* Ophthalmologist,
* Physiotherapist,
* Occupational Therapist,
* Podiatrist,
* Speech and Language Therapist,
* Specialist Services such as Wheelchair, Crutches, Walkers,
* Telecare equipment etc.

**Section Four Other information e.g. Local and National Information**

You may wish to record other personal local and national information relevant to you including:

* Action plans
* Activities
* Benefits
* Community support.
* Guidance
* Laws
* Rights
* Strategies