

[NAME OF PRACTICE]
[PRACTICE ADDRESS]
[PRACTICE TELEPHONE NUMBER]

PERSONALISED CARE PLAN			
PATIENT INFORMATION			
Patient name: Michael Davies	Title:	NHS Number: PE500989A	
		Date of birth: 01 / 09 / 1940	
Address: 72 Ayelsbury Road, Swansea			
Post code: SA1 1PQ			
Is the patient a nursing or care home resident: NO			
Contact details:		Key safe door access code:	
Named accountable GP:		Care coordinator (if appropriate):	
Other named professionals (e.g. care coordinator, other healthcare professionals or social worker) involved in patient's care, if appropriate (include contact details where possible):			
Has information been shared on the patient's behalf?: YES If YES, by whom: Tomm Davies (only applicable where the patient does not have the capacity to make this decision) Patient (or other allowed individual) consent to share information: - with other healthcare professionals involved in the patient's care, e.g. carer, OOH etc: YES - with the multi-disciplinary team: NO			
NEXT OF KIN / CARER / RESPONSIBLE ADULTS INFORMATION			
Name: Tom Davies		Title: Mr	
Address (if different from above):		Post code:	
Contact details: 0712345678		Relationship: Nephew	
Additional emergency contact (if appropriate):			
Name:			
Contact details:		Relationship:	
PATIENTS MEDICAL INFORMATION			
Relevant conditions, diagnosis and latest test results:			
Muscle Atrophy Severe physical impairment Dementia			

Significant past medical history:	
Current medication: lots Date of planned review of medications:	
Allergies:	
KEY ACTION POINTS	
For example: guidance on intervention / deterioration, unmet need to support patient (specify), agreed plan in emergency (ICE)/ useful situation etc.	
OTHER RELEVANT INFORMATION (if appropriate)	
Preferred place of care : Other support services e.g. local authority support, housing Identification of whether the person is themselves a carer (formal or informal) for another person	
Anticipatory care plan agreed: YES / NO/ N/A	Anticipatory drugs supplied: YES / NO/ N/A
Emergency care and treatment discussed: YES / NO	If yes, please specify outcome: e.g.: cardiopulmonary resuscitation – has the patient agreed a DNR or what treatment should be given if seizures last longer than x do y etc.
Date of assessment: / /	Date of review(s):
Any special communication considerations (e.g. patient is deaf or language communication differences):	
Any special physical or medical considerations (e.g. specific postural or support needs or information about medical condition - patient needs at least x mgs of drug before it works etc):	

SIGNATORIES (if appropriate and / or possible)	
Patient signature: Michael Davies	Date: 01/08/2025
Carer (if applicable) signature: Tom Davies	Date: 01/08/2025
Named accountable GP signature: John silver	Date: 01/08/2025
Care Coordinator signature (if applicable):	Date: