Section 13
Learning Disabilities

Traffic Light Form

Red

Amber

Green

Hospital Assessment
Traffic Light Form
for
People with Learning Disabilities

This assessment gives hospital staff important information about you.

Please take it with you if you have to go into hospital.

Ask the hospital staff to hang it on the end of your bed.

Please note: **Value judgements** about quality of life must be made in consultation with you, your family, carers and other professionals. **This includes Resuscitation Status.**

Make sure that all the nurses who look after you read this assessment.

Date of Admission:- Date of Discharge:-

For an electronic version of this form please look at our website: www.ld4u.org.uk

This form is being used with grateful acknowledgement to Kevin Elliott, Lead Health Facilitator, Gloucestershire Partnership NHS Trust, who developed this form and has given permission for us to use it.

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RED-ALERT Things you **must** know about me						
Name		NHS Number				
Likes to be known as …						
Address						
Date of Birth		Tel No				
GP		Address				
Next of Kin		Relationship		Tel No		
Key Worker / main carer		Relationship		Tel No		
Professionals involved				Tel No		
Religion		Religious Requests				
Allergies						
Current medication						
Current medical conditions						
Brief medical history						
Level of comprehension / capacity to consent						
Medical Interventions – how to take my blood, give injections, take temperature, medication, BP etc.						
Behaviours that may be challenging or cause risk						
Heart (heart problems) Breathing (respiratory problems) Eating & Drinking issues - none						
Completed by		Date				

AMBER	Things that are really important to me
Communication How to communicate with me.	
Information sharing How to help me understand things.	
Seeing/hearing Problems with sight or hearing	
Eating (swallowing) Food cut up, choking, help with feeding.	
Drinking (swallowing) Small amounts, choking	
Going to toilet Continence aids, help to get to toilet.	
Moving around Posture in bed, walking aids.	
Taking medication Crushed tablets, injections, syrup	
Pain How you know I am in pain	
Sleeping Sleep pattern, sleep routine	
Keeping safe Bed rails, controlling behaviour, absconding	
Personal care Dressing, washing etc.	
Level of support Who needs to stay and how often.	
Completed by	Date .....

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GREEN Things I would like to happen Likes/dislikes

THINGS I LIKE **Please do this:**	☺	**THINGS I DON'T LIKE** **Don't do this:**	☹
Think about – what upsets you, what makes you happy, things you like to do i.e. watching TV, reading, music. How you want people to talk to you (don't shout). Food likes, dislikes, physical touch/restraint, special needs, routines, things that keep you safe.			

Completed by	Date .....

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