

**What You Need to Know About My Condition**

Click or tap to enter a date.

I have **Post Polio Syndrome,** the symptoms of which vary from person to person. This document contains key information about how Post Polio Syndrome affects me and will help you to understand my needs.

Please be aware that I also have Click or tap here to enter text.

**Full Name** Click or tap here to enter text. **I like to be called** Click or tap here to enter text.

**Address** Click or tap here to enter text.

**Telephone** Click or tap here to enter text. **Mobile** Click or tap here to enter text.

**Next of kin name** Click or tap here to enter text.

**Next of kin telephone** Click or tap here to enter text.

**Next of kin mobile** Click or tap here to enter text.

**In case of emergency contact** Click or tap here to enter text.

**GP name** Click or tap here to enter text.

**GP surgery telephone** Click or tap here to enter text.

**I AM ALLERGIC TO** Click or tap here to enter text.

**BLOOD GROUP** Click or tap here to enter text.

**CURRENT TEST RESULTS** Click or tap here to enter text.

**SPECIAL NOTES** Click or tap here to enter text.

**POST POLIO SYNDROME (PPS)** is the accepted name for the constellation of symptoms including NEW weakness, muscle fatigue and/or “central” fatigue, pain, breathing and/or swallowing difficulties, a variety of sleep disorders, fasciculations, gastrointestinal problems. These symptoms can occur both in previously affected muscles and those thought not to have been affected at onset. There are no definitive tests. Diagnosis is by exclusion of other conditions. **N.B. Care must be taken when prescribing any drug or anaesthetic that has sedative or muscle relaxant properties.**

**Ability and Mobility**

My ability Choose an item. affected by my condition.

My mobility Choose an item. affected by my condition.

I was previously paralysed Click or tap here to enter text. I now have paralysis which affects my Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item.

I have muscle weakness which affects my Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item.

I wear Choose an item. , Choose an item. , Choose an item.

I use a Choose an item. , Choose an item. , Choose an item. , Choose an item. , Choose an item.

I can walk Choose an item. , Choose an item.

I may have my own methods or equipment at home. I may need help if I am not at home.

I Choose an item. getting in and out of bed.

I Choose an item. to turn over whilst in bed.

I Choose an item. getting in and out of chairs.

I Choose an item. getting to and from the bathroom.

Further information on mobility or the methods I use Click or tap here to enter text.

**Communication**

My condition Choose an item. affect my intellect.

I have Choose an item. difficulty in hearing.

I have Choose an item. difficulty in understanding.

I have Choose an item. difficulty in speaking when fatigued.

I have Choose an item. difficulty when fatigued keeping track of conversations.

Further information on my communication needs Click or tap here to enter text.

**Personal Care**

I can take care of Choose an item. of my personal needs.

I Choose an item. help to take a bath or shower.

I Choose an item. help to dress or undress.

Further information on my needs with personal care Click or tap here to enter text.

**Eating and Drinking**

I eat and drink Choose an item.

Further information on my needs when eating or drinkingClick or tap here to enter text.

I have these dietary needs/food allergies Click or tap here to enter text.

**Respiratory**

I have Choose an item.

Further information on my respiratory needs including any settings to note Click or tap here to enter text.

My respiratory consultant is Click or tap here to enter text.

**Medication**

|  |  |  |
| --- | --- | --- |
| **Name of medication** | **Dosage** | **Frequency/time of day taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**As a polio survivor with post polio syndrome care MUST BE TAKEN with anaesthetics and any medication with sedative or muscle relaxant side effects. Due to weakened muscles I need far lower doses.**

**Equipment that is essential during my stay:**

Click or tap here to enter text.

**Useful contacts** (e.g. neurologist, specialist nurse, social worker)

|  |  |  |
| --- | --- | --- |
| **Name** | **Role** | **Telephone** |
| Click or tap here to enter text.  | Click or tap here to enter text.  | Click or tap here to enter text.  |
| Click or tap here to enter text.  | Click or tap here to enter text.  | Click or tap here to enter text.  |
| Click or tap here to enter text.  | Click or tap here to enter text.  | Click or tap here to enter text.  |
| Click or tap here to enter text.  | Click or tap here to enter text.  | Click or tap here to enter text.  |

**Other important information** (e.g. symptoms which may arise which require urgent attention, and what you should do in these circumstances)

Click or tap here to enter text.

**As a polio survivor with post polio syndrome care MUST BE TAKEN with anaesthetics and any medication with sedative or muscle relaxant side effects. Due to weakened muscles I need far lower doses.**

**Thank you for helping to make my stay
as comfortable as possible.**

The Neurological Alliance, **London,** Registered charity 1039034, **www.neural.org.uk**