**EMERGENCY HEALTH CARE PLAN - EHCP**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **To all NIAS/Paramedic/A+E staff** | | | | | | | | |
| **Name:** | |  | | | **DOB:** | | |  |
| **Address:** | |  | | | **HCN:** | | |  |
| **Weight:** | | |  |
| **EMERGENCY CONTACT NUMBERS** | | | | | | | | |
| **Name** | | | **Relationship** | | | **Contact Number** | | |
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| **DIAGNOSIS** | | | | | | | | |
|  | | | | | | | | |
| **DOCTOR WHO KNOWS PATIENT BEST** | | | | | | | | |
| **Name:** |  | | | **Contact Number:** | | |  | |
| **TYPE OF EMERGENCY TREATMENT REQUIRED FOR IMMEDIATELY REVERSIBLE CAUSES**  eg. Choking, Anaphylaxis, Blocked tracheostomy, Seizure (please state) | | | | | | | | |
|  | | | | | | | | |
| **KNOWN ALLERGIES** | | | | | | | | |
|  | | | | | | | | |
| **THINGS THAT SHOULDN’T BE DONE** | | | | | | | | |
|  | | | | | | | | |
| **ACTIONS TO BE TAKEN IN THE EVENT OF CARDIORESPIRATORY ARREST** | | | | | | | | |
|  | | | | | | | | |
| **PREFERRED PLACE OF DEATH (if appropriate)** | | | | | | | | |
|  | | | | | | | | |

**Child/Parent [PR] signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SUMMARY OF CONDITION**  Including diagnosis and expected trajectory.  Medical devices in situ (eg. VP shunt, PEG, NG, Tracheostomy, Baclofen pump, VNS device, pacemaker etc) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **SALIENT POINTS**  eg. Deaf, blind, no verbal communication but able to understand, use of electronic communication device. | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **MEDICATION on [Date]** | | | | | | | | | | | |
| **Drug** | **Dose** | | **Route** | | **Frequency** | **Drug** | | | **Dose** | **Route** | **Frequency** |
|  |  | |  | |  |  | | |  |  |  |
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| **RESCUE MEDICATION** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **PROFESSIONAL CONTACT DETAILS** | | | | | | | | | | | |
|  | | **Name** | | | | | **Contact Number** | | | | |
| **Hospital Ward** | |  | | | | |  | | | | |
| **Paediatrician – Hospital**  **GMC No** | |  | | | | |  | | | | |
| **Community Paediatrician**  **GMC No** | |  | | | | |  | | | | |
| **GP** | |  | | | | |  | | | | |
| **Community Nursing** | |  | | | | |  | | | | |
| **Palliative Care Nurse** | |  | | | | |  | | | | |
| **Other (specialists)** | |  | | | | |  | | | | |
| **COPIES (please tick if provided with copy of Emergency Care Plan)** | | | | | | | | | | | |
| Patient (eg wheelchair) □ | | | | Parents[PR] □ | | | | School □ | | | |
| Respite Unit □ | | | | NIAS □ | | | | Emergency Department □ | | | |
| Ward □ | | | | CCN □ | | | | GP □ | | | |

***Please note this plan can be reviewed/changed at any time following discussion with child or those with parental responsibility***