NHS
London North West
University Healthcare
NHS Trust

# MY POUCH CARE PASSPORT

ST MARK'S HOSPITAL

NHS
London North West University Healthcare
NHS Trust

## PERSONAL DETAILS

| | | | |
|---|---|---|---|
| Patient Name | | Telephone | |
| Date of Birth | | Email | |
| Hospital Number | | Address | |
| NHS Number | | | |
| GP Practice | | Telephone | |
| | | Email | |
| NEXT OF KIN (Relationship) | | Telephone | |
| | | Email | |
| Consultant Surgeon | | | |
| Consultant Gastroenterologist | | | |

## POUCH/STOMA RELATED CONDITIONS/SURGERIES

(Include any pouch/stoma related surgeries or conditions - Please include date)

**(Ple ase click on the ☐ to highlight your answer as such ☑)**

| | | |
|---|---|---|
| Colonic Neoplasia (cancer, dysplasia) | ☐ No | ☐ Yes (specify in section above) |
| FAP (Familial Adenomatous Polyposis) | ☐ No | ☐ Yes (specify in section above) |
| PSC (Primary Sclerosing Cholangitis) | ☐ No | ☐ Yes (specify in section above) |
| Chronic Pouchitis | ☐ No | ☐ Yes (specify in section above) |

## OTHER CONDITIONS AND SURGERIES

(Include any other non pouch/stoma related surgeries or conditions - Please include date)

## MEDICAL CONDITIONS

Please specify (Answer 'Not applicable' when condition not relevant to you)

| | |
|---|---|
| **HEART** (Heart problems, palpitation, high/low blood pressure, etc. - Please specify) | |
| **LUNGS** (Breathing problems, Asthma, COPD, Cough, etc. - Please specify) | |
| **KIDNEYS AND BLADDER** (Incontinence, kidney/bladder problems, etc. - Please specify) | |
| **DIGESTIVE SYSTEM** (IBD, IBS, Acid reflux, liver problems, bowel incontinence, etc. - Please specify) | |
| **NERVOUS SYSTEM** (Memory, learning disability, epilepsy, migraine, pins and needles, stroke, pain, etc. - Please specify) | |
| **MUSCULOSKELETAL** (Arthritis, Muscle/joints problems, hip/knee replacement, etc. - Please specify) | |

| | |
|---|---|
| **MALE REPRODUCTIVE SYSTEM** (Erectile dysfunction, prostate problems, etc. - Please specify) | |
| **FEMALE REPRODUCTIVE SYSTEM** (Pregnancy, menopause, hormonal replacement therapy, etc. - Please specify) | |
| **BLOOD DISORDERS** (Bleeding, clots, etc. - Please specify) | |
| **SKIN HEALTH** (Psoriasis, dermatitis, etc. - Please specify) | |
| **MENTAL HEALTH** (Anxiety, depression, stress, etc. - Please specify) | |
| **SENSORY ORGANS** (Hearing problems, Vision problems, etc. - Please specify) | |
| **ENDOCRINE SYSTEM** (Diabetes, hormonal issues, thyroid problems, etc. - Please specify) | |

## ALLERGIES/INTOLERANCES TO MEDICATIONS/FOOD

(Please state type of reaction)

## SPECIAL DIET

(Vegetarian, Vegan, Gluten free, Lactose free, other - Please specify)

## MY MEDICATIONS

(Indicate dose and frequency)

| | |
|---|---|
| **ON PRESCRIPTION** (Please list medications) | |
| **OVER-THE-COUNTER MEDICATIONS** (Please list medications) | |
| **SUPPLEMENTS VITAMINS PROBIOTICS HERBAL MEDICINE RECREATIONAL DRUGS OTHERS** (Please list medications) | |

**(Please click on the ☐ to highlight your answer as such ☒)**

| | |
|---|---|
| **HORMONAL REPLACEMENT** (Women ONLY) | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **CONTRACEPTIVES** (Women ONLY) | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **ANTIBIOTICS** | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **BLOOD THINNERS** | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **ANTIDIABETIC MEDICATIONS/ INSULIN** | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **LAXATIVES/ANTIDIARRHEAL** | ☐ No ☐ Yes (specify in 'My medication' section above) |
| **PAIN RELIEVE** | ☐ No ☐ Yes (specify in 'My medication' section above) |

## SOCIAL SITUATION

(Answer 'Not applicable' when not relevant to you)

| | |
|---|---|
| **SMOKING** (specify amount) | |
| **ALCOHOL** (specify amount, frequency) | |
| **WORK/SCHOOL/ RETIRED** (Specify, include line of work if applicable) | |
| **LIVING** (Alone, with family, specify) | |
| **EXERCISE** (Specify type of activity) | |

| STOMA FUNCTION (If Applicable) | |
|---|---|
| **STOMA BAG EMPTYING IN 24H** (Specify frequency) | |
| **STOMA BAG CHANGE** (Daily, every other day, etc.) | |
| **USE OF MEDICATIONS** (Loperamide, Codeine, Emix, Dioralyte, etc. - Please specify) | |
| **COMPLICATIONS** (Leaks, sore skin, allergy, Pyoderma, high output stoma, hernia, prolapse, retracted stoma, etc. - Please specify) | |
| **DELIVERY COMPANY** (Charter, Fittleworth, Medilink, etc.) | |
| **LOCAL STOMA NURSE** (Hospital and contact details) | |
| **PRODUCTS** (Brand of stoma bag, accessories, product codes/reference number) | |

## ILEOANAL POUCH FUNCTION (IF APPLICABLE)

| | |
|---|---|
| **POUCH FREQUENCY** (Total amount in 24h - Day/Night) | |
| **USE OF MEDICATIONS** (Loperamide, Codeine, Psyllium husk, antibiotics, Probiotics, Dioralyte, E-Mix, etc.) | |
| **INCONTINENCE** (Seepage - Small amount, Leakage - Large amount, Day/Night) | |
| **URGENCY** (Feeling the need to rush to the toilet without being able to hold 15-20 min) | |
| **INCOMPETE EMPTYING** (Feeling the need to empty the pouch shortly after going to the toilet) | |
| **EVACUATION DIFFICULTIES** (Straining, requiring aids to empty the pouch) | |
| **USE OF DEVICES** (Hegar dilator, Medena catheter, Irrigation device, anal plug, etc. - Please specify) | |
| **PERIANAL SKIN** (Healthy, red/sore, etc. - Please specify) | |
| **USE OF SKIN BARRIER** (Barrier ceam, Barrier wipes, etc. - Please specify, include brand) | |
| **STRESSORS** (Work, home, lifestyle, etc. - Please specify) | |
| **RESTRICTIONS** (Social, work, dietary, sexual) | |
| **OTHER POUCH RELATED COMPLICATIONS** | |

# St Mark's Internal Pouch Care

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|---|---|
| Telephone | 0208 453 2099 |
| Email | LNWH-tr.internalpouchcare@nhs.net |
| Website | https://www.stmarkshospital.nhs.uk/stoma-care/ |
| Pouch Book | LNWH-tr.stm-pouchbook@nhs.net |

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