

**INFORMATION ABOUT MY CARE NEEDS BECAUSE OF CF**

Alms No:

**PERSONAL INFORMATION**

**DLA (N.H.I) Ref No:** .....

**Name of applicant:** .....  
(If parent)  
**(Child / Adult with CF):** .....

**Date of birth:** .....

**Address:** .....  
.....  
.....

**Postcode:** .....

**Telephone No:** .....

**Email:** .....

**Hospital attended:**.....

**Rate of Benefit currently receiving (please circle/delete)**  
**Care Component**                      **Mobility Component**  
H / M / L / Nil                      H / L / Nil

**Rate of Benefit offered:**  
**Care component**                      **Mobility component**  
H / M / L / Nil                      H / L / Nil

**TREATMENT/MEDICATION CARE NEEDS**

<b>Physiotherapy</b>	<b>no. of times daily</b>	<b>no. of minutes per session</b>
	<input type="text"/>	<input type="text"/>

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<b>Antibiotics</b>		
<b>Oral</b>	<b>no. of times daily</b>	<b>method of delivery</b>
<b>(please list)</b>		<b>e.g. spoon / syringe /other</b>
	<input type="text"/>	

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**Antibiotics  
Nebulised  
(please list)**

**no of times daily**

**time taken**

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**Home Intravenous Therapy**

**Yes / No**

**IV's**

**no of times daily**

**length of course**  
e.g. 2 weeks

**frequency**  
e.g. every 3 months

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**No. of Chest infections in the last 6 months?**

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**Other Nebulised Therapy**

**Yes/No**

**Name**

**no of times daily**

**time taken**

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**Inhalers**

**Yes/No**

**Name**

**no of times daily**

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**Does anyone help you with any/all of the above treatment and in what way?**

**NUTRITIONAL CARE NEEDS**

**Pancreatic Enzymes (Creon)**

**Yes/No**

**Vitamin Supplements (please list)**

**no of doses daily**

**Food supplements**

**times daily**

**CARE NEEDS**

You need to show that your disability means that you require frequent attention throughout the day and/or night in connection with your 'bodily functions' such as getting out of bed, bathing, shaving, going to the toilet, dressing, walking, breathing, eating and for adults (over 16) preparing and cooking a meal.

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*Other care requirements relating to nutrition e.g. encouragement to eat, weight problem, overnight feeding, help with preparing/cooking a meal*

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*Any surgically fitted devices, e.g. portacath, gastrostomy*

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*Other difficulties that create care needs e.g. nose bleeds, nasal polyps, excessive sweating, diabetes, stomach cramps, joint pain, anxiety etc.*

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*Care required during the Night e.g. coughing, physio, inhaler, nebuliser, change of bedlinen etc.*

*Reason for Help:*

**No of times Per Week**

**Per Night**

**Length of Time**

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**MOBILITY NEEDS**

***Approximately how far can you/your child walk before experiencing difficulty?***

***a. When Well.....***

***b. When Unwell.....***

***What difficulties are experienced e.g. bout of coughing, breathlessness, tightness in chest, stiff or sore joints etc.***

***Tell us about the speed of walking and at what stage these difficulties occur***

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***Does CF create any other extra care needs in order to take part in social, leisure and/or cultural***

***Activities?                      Yes/No***

***If yes, please give details;***

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***Please tell us here about anything else that may be relevant that has not been mentioned***

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***Please return your completed form to the Support Service for preparation of a personalised support letter.***

***Helpline number: 0845 859 1000***

***CF Trust, 11 London Road, Bromley, Kent, BR1 1BY***