Quick start

Start now, even halfway through care

Use any A4 folder. Print the dividers, current-information sheet, medicines list and an appointment sheet. Put current information first. Add what you know today, date it, and write “not sure” where needed. A current pharmacy list can go beside it. You can start without all your old letters.

Before the very next appointment

Write the date, the service and the one thing you most want help with. Add up to three questions, changes since the last visit, and anything you did not understand. Bring relevant letters and your current medicines information. Ask for communication or access support through the service if needed.

During the appointment

Use the sheet as a prompt, not a form you must finish. Take short notes or ask someone you trust to help, with your permission. Ask: “Can I read back what I understood and check whether I have missed anything?” This is a check of your understanding, not a request for a signature or approval of the folder.

Before you leave

Check the next step: what happens, who arranges it, and by when? If there are tests, how will results reach you and who should you contact if they do not? Ask what changes mean you should seek help sooner, and where to get that help. Note anything still unclear.

Afterwards, and between visits

Read your notes while the visit is fresh. Add a date and source when updating current information. Put open tasks on the follow-up tracker. Keep original letters intact. Move outdated summaries to Older information and mark them “superseded”. Add old letters gradually, newest first within each section.

Keep it useful and private

You choose what to share. Keep the folder safe and check shared printers. Do not send completed sheets to the project. The folder may be incomplete; it does not replace clinical records or monitor your care. Ask a clinician or pharmacist about unclear instructions before changing treatment. Do not wait for paperwork when you need care.

Current information

Your summary as of a date. It may be incomplete. Keep source documents alongside it.

Name / chosen identifier: **Updated on:**

Prepared by (if someone helped): With my permission: yes / no

What matters to me / communication and access needs

Current health information I want to share

Include the source and date where known. Mark questions or uncertainty clearly.

Allergies or previous reactions I know about

What caused the reaction? What happened? Source / date? Write “not sure” if uncertain.

Medicines information is kept here:

List date / source: Includes non-prescription products? yes / no / not sure

People / services involved in my care

Name or service | role | contact route (keep personal details inside the folder)

Current plan and things waiting to happen

Source and date | See Waiting and follow-up for open items.

What needs checking / information that does not match

My medicines information

Optional worksheet. You can use an existing current pharmacy or HSE medicines list instead.

Name / chosen identifier: **Updated on:**

Information came from / list date:

Include medicines you take regularly or occasionally, non-prescription products, vitamins and supplements. Copy instructions from a current source; write “not sure” and ask a pharmacist or clinician about gaps or differences. This is not a prescription.

Name and strength	How much I take, how I take it and when	Regular / as needed; instructions or limits	Source / date; notes or questions

Allergies / reactions: what caused them and what happened?

Include source / date. Write “not sure” if uncertain.

Do not change treatment because of this worksheet. Keep it current after advice from your clinical team and mark replaced lists “superseded”. Use another dated sheet if you need more rows.

Appointment sheet

One sheet per visit. Blank boxes are fine. Continue on the back if needed.

Name or chosen identifier: **Date / time:**

Service / clinician: Visit type: in person / phone / video

BEFORE | What matters most to me today?

My questions | Choose up to three

1.

2.

3.

Changes since the last visit / information to bring

Bring your current medicines list and relevant letters. Mark uncertain details “not sure”.

DURING | What I understood from the conversation

“Can I read back what I understood and check whether I have missed anything?”

NEXT | What happens, who arranges it, and by when?

For tests: who reviews the result, how will I hear, and whom do I contact if I do not?

What changes mean I should seek help sooner, and how?

Record advice from the clinician. This sheet does not provide medical advice.

Still unclear / contact for questions

Checking understanding is not sign-off. No clinician signature is needed. Ask about unclear instructions before changing treatment. Do not wait for paperwork when you need care.

Waiting and follow-up

An optional reminder for you. This sheet does not monitor results or contact anyone.

Name / chosen identifier:	**Sheet started on:**

Write the agreed contact route and expected date. If no date was given, ask. Do not assume that no news means a normal result. Seek care when you need it; do not wait for this list.

What am I waiting for?	**Who arranges / reviews it? Contact route**	**Expected by / when to ask**	**What happened? Date / next step / closed**

Close an item only when you know what happened or have an agreed next step. If a date changes, record the new date and who gave it. Keep the original appointment sheet or letter.

Folder dividers

Print A4, single-sided. One divider per section. Colour is not needed.

01

Current information

Start here. Your dated summary and current medicines information.

Keep source documents alongside your notes. Mark uncertainty. Move replaced summaries to Older information.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.

02

Appointments

One sheet for each visit. Put the next blank sheet at the front.

Before: your priorities and questions. During: what you understood. After: the next step, owner, date and contact route.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.

03

Letters and care plans

Copies of letters and plans, newest first.

Keep originals intact. Note where each document came from. If two documents disagree, ask the relevant service to clarify.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.

04

Tests and results

Copies of test information and results, newest first.

Keep the accompanying explanation or contact route. Put missing results in Waiting and follow-up. Do not interpret an unexplained result using this pack.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.

05

Waiting and follow-up

Open items: what happens next, who arranges it, and by when.

Use the tracker if it helps. Do not assume silence means a normal result. The folder does not chase or monitor anything for you.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.

06

Older information

Superseded summaries and older papers you want to keep.

Label replaced summaries “superseded” with a date. Add older letters gradually. An incomplete archive does not stop you starting today.

Use only the sections that help you. Keep personal information inside your folder, not on its outside cover.