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 Move outdated summaries to Older information and mark them “superseded”.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.