Health Passport

First name: 

Last name: 

I like to be known as: 

Please return this Passport to me when I leave.
1. Personal Details

a) NHI number: ____________________________

b) Address: ________________________________

________________________________________

________________________________________

c) Telephone: ___________ Mobile: ___________ Fax: ___________

d) Email: ____________________________________________

Date of completion: _________________ (see Updates page for changes, if any)

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Notes for person completing the passport:

• Completing this passport is optional. You may decide how much information you want
to give under each section and may even choose not to complete some sections of the
passport.

• If you are unsure what to write in a particular section, please refer to the Guide to
Completing the Health Passport.

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Notes for medical and support staff:

• If you are involved with my care and support, please read this passport.

• This is not my Medical Record. This passport gives information about:

  — Things you MUST know about me (Section A)
  — Things that are Important to me (Section B)
  — Other Useful information (Section C)

• Please return this passport to me when I leave.
Section A: Things you MUST know about me

2. This is what I want to tell you about myself

(You may wish to write here about your impairment or other health condition/s. For example: I have cerebral palsy; I have epilepsy and my seizures vary from mild seizures to strong seizures that may last up to 3 minutes; I have Alzheimer’s disease; etc.)
3. My Communication

a) My first (or preferred) language is: _________________________________

b) I can also use: _________________________________ language/s

c) Do I need an interpreter? NO / YES: _________________________________ language

d) I communicate with people using: (e.g., gestures, facial expressions, picture charts, hearing aid, digital diary, electronic communicator, etc)

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e) Things you need to know when communicating with me are:
(e.g., speak slowly, face me, tap my shoulder for attention, turn on my equipment, etc)

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4. Things to know when providing medical care

a) You would know I am in pain when: (e.g., I can tell you, I make a particular sound, I rock my body, etc)

b) I am allergic to: (e.g., certain medicines, perfume, nuts, etc)

c) When giving me medication, please: (e.g., crush my tablets)

d) When conducting a medical examination, please: (e.g., be aware of my catheter bag, lie me on my left side, etc)

e) Other things that you need to know about my medical care: (please provide other information not already covered that staff must know about you)
5. Decision-making

I can and would like to make my own decisions, so please ask me first.

If, for some reason, I am incompetent or unconscious at the time when the decision needs to be made, the following will apply:

a) Do I have a legal representative? Yes / No (see item (b) below)

My legal representative is: ________________________________

Full name: ________________________________

Legal relationship: (e.g., welfare guardian, enduring power of attorney, etc)

________________________________________

Telephone: ____________ Mobile: ____________ Fax: ____________

Email: ________________________________

b) Do I have advance directives? Yes / No (see item (c) below)

My advance directives can be found at (e.g., on my medical file, in cupboard at home, I have given verbal directives to my eldest son, etc):

________________________________________

(c) (Please note that this section applies only if I have ticked ‘No’ to both sections a and b above.) I do not have a legal representative or advance directives and trust that any decision concerning my care and welfare will be made by appropriate professional/s in my best interests after taking into account my views if they are known, or consulting people who know me and care about me.
6. Safety

(Circle one statement that applies to you)

* I don’t need support with my safety. Please go to Section B.

* I may need support in keeping safe. Please read information below.

a) **Things important for my physical safety:** (e.g., raised bed rails, my chest harness, sharp objects removed from room, to be watched as I tend to run away, etc)

b) **Things that upset me or cause me stress are:** (e.g., bright lights, loud noise, etc)

c) **You would know that I am anxious or stressed when:** (e.g., I start rocking my body, I start biting myself, I start banging my hands, etc)

d) **Things you could do to help me settle down are:** (e.g., play soft music, take me out for a walk, call the crisis team, etc)
Section B: Things that are important to me

7. Moving around

(Circle one statement that applies to you)

* I don’t need support with moving around. Please go to item 8.

* I may need support with moving around. Please read information below.

a) I move around using: (e.g., I can walk with the support of a wall, I can see only up to a certain distance, I use a hoist for transfers, I have a guide dog, etc)

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b) Things you need to know when supporting me to move around: (e.g., roll me on one side when helping me to move in bed, let me hold your left arm when you are guiding me, please put my power wheelchair on charge at night, etc)

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8. Daily activities

(Circle one statement that applies to you.)

* I don’t need support with daily activities. Please go to item 9.

* I may need support with daily activities. Please read information below.

a) Using toilet

I can: ____________________________________________________________

________________________________________________________________

You can support me with: __________________________________________

________________________________________________________________

Things to be aware of: _____________________________________________

________________________________________________________________

b) Washing/ Taking shower

I can: ____________________________________________________________

________________________________________________________________

You can support me with: __________________________________________

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Things to be aware of: _____________________________________________

________________________________________________________________

c) Grooming & personal hygiene

I can: ____________________________________________________________

________________________________________________________________

You can support me with: __________________________________________

________________________________________________________________

Things to be aware of: _____________________________________________

________________________________________________________________
d) Dressing

I can: ____________________________________________________________

_______________________________________________________________

You can support me with: _________________________________________

_______________________________________________________________

Things to be aware of: ___________________________________________

_______________________________________________________________

e) Eating & drinking

I can: ____________________________________________________________

_______________________________________________________________

You can support me with: _________________________________________

_______________________________________________________________

Things to be aware of: ___________________________________________

_______________________________________________________________

f) Sleeping

I can: ____________________________________________________________

_______________________________________________________________

You can support me with: _________________________________________

_______________________________________________________________

Things to be aware of: ___________________________________________

_______________________________________________________________
9. Important people in my life:

a) Next of kin (e.g., your spouse, family member, relative, or a friend):

Full name: _____________________________________________________________

Relationship to me: ____________________________________________________

Telephone: _____________ Mobile: _____________ Fax: _____________

Email: __________________________________________________________________

b) Support person: (e.g., your key support worker in the house where you live)

Full name: _____________________________________________________________

Relationship to me: ____________________________________________________

Name of agency: (if applicable) ____________________________________________

Telephone: _____________ Mobile: _____________ Fax: _____________

Email: __________________________________________________________________

c) General practitioner:

Full Name: _______________________________________________________________

Address: __________________________________________________________________

Telephone: _____________ Mobile: _____________ Fax: _____________

Email: __________________________________________________________________

d) Any other person or agency and their contact details: _______________________

________________________________________________________________________
Section C: Other useful information

a) Things I like: (e.g., music, routines, etc)

b) Things I don’t like: (e.g., certain food, dark rooms, etc)

c) My religious needs: (e.g., karakia/ prayers, Halal food, etc)

d) My cultural needs: (e.g., I prefer a woman doctor, etc)

e) Other information: (e.g., tell me when you bring food and what’s in it, etc)
Section D: Updates

When there are any changes to your support needs, cross out the original comments and complete this section.

1. Date: _______________  Updated by: ________________________________
   Details: __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

2. Date: _______________  Updated by: ________________________________
   Details: __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

3. Date: _______________  Updated by: ________________________________
   Details: __________________________________________________________________
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4. Date: _______________  Updated by: ________________________________
   Details: __________________________________________________________________
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Acknowledgement:
This passport is based on original work entitled, ‘This is my Hospital Passport’ by Wandsworth Community Learning Disability Team, UK.

Disclaimer:
The Health and Disability Commissioner provides this passport template as a guide only and accepts no responsibility for the accuracy of the information completed in the passport.
Please return this Passport to me when I leave.

To provide feedback on the design and format of the passport, please contact:

Health & Disability Commissioner
PO Box 1791, Auckland 1140.
Free Phone: 0800 11 22 33; Fax: 09 373 1061
Email: healthpassport@hdc.org.nz
Website: www.hdc.org.nz