HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Health Passport

First name:

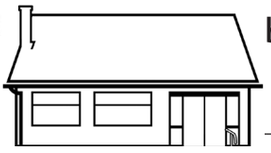
Last name:

I like to be known as:

Please return this Passport to me when I leave.

1. Personal Details

a) NHI number: _____



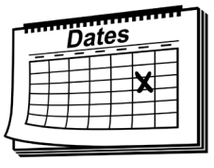
b) Address: _____

_____

_____

c) Telephone: _____ Mobile: _____ Fax: _____

d) Email: _____



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

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.

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)

_____

_____

_____

_____

_____

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)

_____

_____

_____

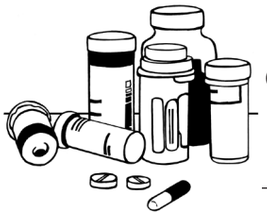
_____

_____

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)

_____

_____

_____

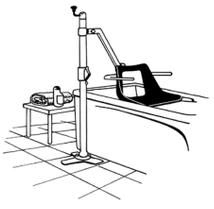
c) (Please **note** that this section applies only if I have ticked 'No' to both sections a and b above.) **I do not have a legal representative or advance directives and trust that any decision concerning my care and welfare will be made by appropriate professional/s in my best interests after taking 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.

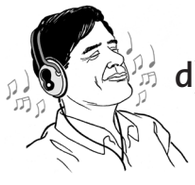
* I may need support in keeping safe. Please read information below.



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)

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)

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: _____

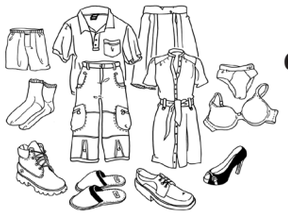
Things to be aware of: _____

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:**

_____

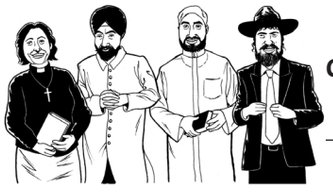
_____

_____

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: _____

_____

_____

Acknowledgements:

This passport is based on original work entitled, 'This is my Hospital Passport' by Wandsworth Community Learning Disability Team, UK.

All pictures are from the CHANGE picture banks: www.changepeople.co.uk.

Thank you to everyone who helped in the redesign of this document.

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

HEALTH & DISABILITY COMMISSIONER
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