# My Health Journey

## Hospital Passport

The information in this passport will assist Health staff to better support me and meet my needs in hospital and after discharge. This passport stays with me at all times. I give consent for the information in this passport to be used for the purpose of supporting me in hospital and after discharge. The information is not to be used or shared for any other purpose.

Name _____ Date _____

blue sky community services

NSW GOVERNMENT Health
Mid North Coast
Local Health District

# My Health Journey

**Note to Participant** - It is important that the information in this *My Health Journey - Hospital Passport* remains as current as possible. The more accurate the information, the better Health staff can support you in hospital. Please review your Passport often and update pages as needed. Keep a printed copy of your Passport in a plastic sleeve ready to take with you to hospital.

## My Details

Pronoun: (optional)

Given names:

Surname:

Preferred name:

Gender:

Female:

Male:

Non-binary:

Prefer not to say:

Prefer to self describe:

Contact phone:

Medicare card no:

Concession or Health Care card no:

Are you an NDIS participant? YES NO

NDIS participant number: (if yes)

**My NDIS Contact:**
eg. Support Coordinator, NDIA Delegate, Local Area Coordinator, Early Childhood Coordinator

Name:

Organisation:

Contact phone:

Email:

If you are not an NDIS participant, would you like more information about the NDIS? YES NO

**Mid North Coast NDIS Partners**

Northcott:

Early Childhood Approach Age 0-8

1800 118 481

ECEI@northcott.com.au

Blue Sky Community Services:

Age 9+

1800 241 675

bluesky@ndis.gov.au

**My GP:**

Name:

Practice:

Contact phone:

Email:

**My Main Contact Person:**

Name:

Relationship:

Contact phone:

Email:

**My Behaviour Support Practitioner:**
(if applicable)

Name:

Organisation:

Contact phone:

Email:

# My Health Journey

## Identified Disabilities

- ☐ Developmental Delay (age 0-6)
- ☐ Intellectual or Cognitive Impairment
- ☐ Learning Disability (other than Intellectual)
- ☐ Autism Spectrum Disorder (including Asperger's)
- ☐ Acquired Brain Injury
- ☐ Neurological Condition
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Physical Disability
- ☐ Other

Would you like to provide more detail about your disability?

## Cultural, Spiritual & Staffing Considerations

Where possible, you can identify staff you prefer to support you while you are in hospital. Example: Social Worker, Aboriginal Liaison Officer, Chaplain, male or female staff.

(provide details if applicable)

## Documentation

The following documentation is in place:
(tick all applicable)

- ☐ Advanced Care Plan
- ☐ Guardianship Orders
- ☐ Power of Attorney
- ☐ Other

Have you brought a copy with you to hospital?

YES ☐ NO ☐
YES ☐ NO ☐
YES ☐ NO ☐
YES ☐ NO ☐

## Living Arrangements

I live:

- ☐ with family member/s
- ☐ with friend/s
- ☐ with paid carer/s
- ☐ by myself
- ☐ other

Type of residence:

- ☐ Supported accommodation
- ☐ Private home
- ☐ Public/Community housing
- ☐ Residential aged care facility
- ☐ Other

Are access needs at your home currently met? (please provide details)

# My Health Journey

## Communication

My first language is:

I communicate verbally: YES ☐ NO ☐

I require an interpreter: YES ☐ NO ☐

I use the following devices to help me communicate:
(please provide details)

The following helps me to understand you:

Simple words ☐
Short sentences ☐
Pictures or diagrams ☐
Examples ☐
Demonstration ☐
Checking my understanding along the way ☐
Letting me explain things back to you ☐
Letting my carer/support person explain things ☐
Other ☐

Would you like to provide more detail about communication?

## Equipment

I use the following equipment to support me:

Have you brought this equipment with you to hospital?

| | |
|---|---|
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |
| | YES ☐ NO ☐ |

How and when I use my equipment:

How best to support me while using my equipment:
(eg. sometimes I have trouble with my balance, you can support me by . . .)

# My Health Journey

## Activities of Daily Living

My level of independence: (please tick appropriate box)

| | Can do myself | Can do with help | Cannot do |
|---|---|---|---|
| Sit | ☐ | ☐ | ☐ |
| Stand | ☐ | ☐ | ☐ |
| Walk | ☐ | ☐ | ☐ |
| Navigate steps | ☐ | ☐ | ☐ |
| Transfer | ☐ | ☐ | ☐ |
| Roll over in bed | ☐ | ☐ | ☐ |
| Get out of bed | ☐ | ☐ | ☐ |
| Use the toilet | ☐ | ☐ | ☐ |
| Shower | ☐ | ☐ | ☐ |
| Dress | ☐ | ☐ | ☐ |
| Eat | ☐ | ☐ | ☐ |
| Drink | ☐ | ☐ | ☐ |
| Read | ☐ | ☐ | ☐ |
| Write | ☐ | ☐ | ☐ |

I have difficulties eating, drinking or swallowing: YES ☐ NO ☐

If yes, outline the difficulty and what helps:

I have allergies or adverse reactions: YES ☐ NO ☐

If yes, please provide details:

I usually sleep through the night: YES ☐ NO ☐

I'm usually okay with strangers: YES ☐ NO ☐

I make friends easily: YES ☐ NO ☐

Routines that are important to me:

Goals I am working on:

# My Health Journey

## My Supports

Use the template below to show your current informal, mainstream and funded supports:

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| AM | | | | | | | |
| PM | | | | | | | |

Who provides the above supports:

Name:

Relationship/Role:

Contact phone:

Email:

Name:

Relationship/Role:

Contact phone:

Email:

Name:

Relationship/Role:

Contact phone:

Email:

Name:

Relationship/Role:

Contact phone:

Email:

Name:

Relationship/Role:

Contact phone:

Email:

Name:

Relationship/Role:

Contact phone:

Email:

# My Health Journey

## More About Me

Supports I require during a medical assessment:

How you know something hurts me:

How I go to the toilet (manage continence):

Questions that may need to be answered in a particular way:

Things I don't like and things that make me anxious:

Things that help me feel comfortable and calm:

Usual behaviours for me:

I have a Positive Behaviour Support Plan: YES / NO ☐ ☐
Details:

# My Health Journey

## Health & Medical Information

Health Professionals who support me in the community:

### Health Professional

Name:

Role:

Organisation/Practice

Contact phone:

Email:

Please keep a copy of your current medications list attached to this Hospital Passport. Your pharmacy can provide this.

### My Usual Pharmacy

Name:

Address:

Contact phone:

### Health Professional

Name:

Role:

Organisation/Practice

Contact phone:

Email:

### Health Professional

Name:

Role:

Organisation/Practice

Contact phone:

Email:

Outline your medical and treatment history below:

| Condition | Treatment/Surgery | Treatment/Surgery Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# My Health Journey

## Other things I would like you to know about me (if any)