My 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



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)			Are you an NDIS participant?	YES	NO
Given names:			NDIS participant		
Surname:			number: (if yes)		
Preferred name:			My NDIS Contact: eg. Support Coordinator,	NDIA Delegate	e, Local
Gender:	Female:		Area Coordinator, Early (•	
			Name:		
	Male:		Organisation:		
	Non-binary:		Contact phone:		
	Prefer not to say:		Email:		
	Prefer to self describ	oe:	If you are not an N participant, would		



Medicare card no:

Concession or Health Care card no:

My GP:

Name:

Practice:

Contact phone:

Email:

My Main Contact Person:

Name:

Relationship:

Contact phone:

Email:

likemoreinformationabout the NDIS?YESNO



My Behaviour Support Practitioner: (if applicable)

Name:

Organisation:

Contact phone:

Email:

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

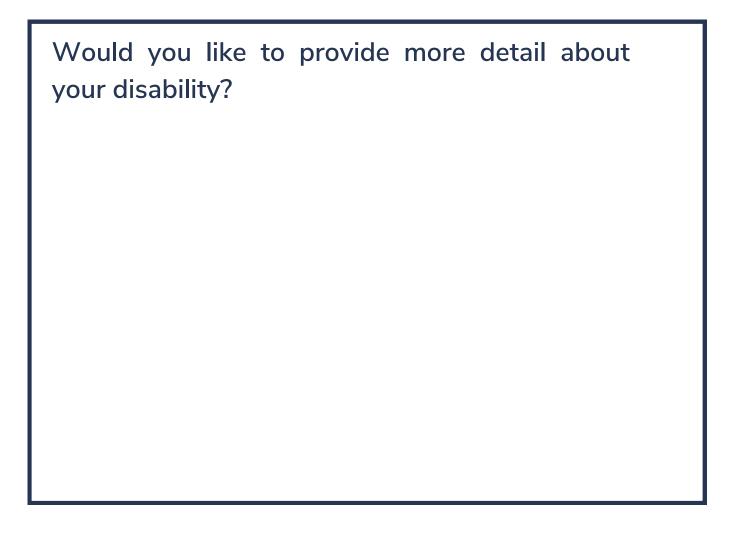
Neurological Condition

Hearing Impairment

Vision Impairment

Physical Disability

Other



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)	Have you brought a copy with you t	to ho
Advanced Care Plan	YES NO	
Guardianship Orders	YES NO	
Power of Attorney	YES NO	
Other	YES NO	

Living Arrangements

l live: with family member/s with friend/s with paid carer/s by myself other

ospital?

YES	NO
YES	NO
YES	NO

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)

Communication

My first language is:			The following h
communicate verbally:	YES	NO	
require an interpreter:	YES	NO	
I use the following devices to (please provide details)	help me con	nmunicate:	Checking my understa Letting me expla Letting my carer/support p Other

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 thing my carer/support person explain things

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

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 . . .)

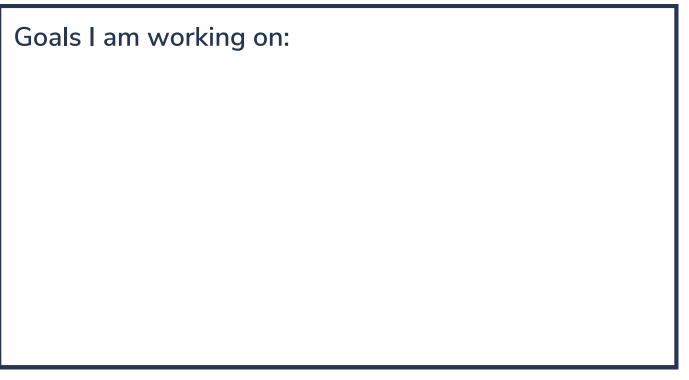
Activities of Daily Living

My level of independence: (please tick appropriate box)

	Can do myself	Can do with h	elp 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,		Ιι	isually sleep through the
drinking or swallowing:	YES	NO	n usually okay with stra
If yes, outline the difficul	ty and what helps:	lr	nake friends easily:
		F	Routines that are import
L have allergies or			
l have allergies or adverse reactions:	YES	NO	

I usually sleep through the night:	YES	NO
I'm usually okay with strangers:	YES	NO
I make friends easily:	YES	NO

ant to me:





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:

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:



Health & Medical Information

Health Professionals who support me in the community:

Health	Professional

Name:

Role:

Organisation/Practice

Contact phone:

Email:

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:

Outline your medical and treatment history below:

Condition	Treatment/Surgery	Treatment/Surgery Date



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