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My Health Passport

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If you are a health care professional who will be helping me,

PLEASE READ THIS

before you try to help me with my care or treatment.

Please keep this with my other notes, and where it may be easily referenced.

My full name is: _____

I like to be called: _____

This passport has important information so you can better
support me when I visit/stay in your hospital or clinic.

Date completed ____/____/____

You can talk to this person about my health: _____

Phone number: _____ Relationship: _____

I am allergic to: (list medications or foods, e.g. penicillin, peanuts)



I communicate using: (e.g. speech, preferred language, sign language, communication devices or aids, non-verbal sounds, also state if extra time/support is needed)



When I take my medication, I prefer to take it: (e.g. with water, with food)



If I am in pain, I show it by: (also note if I have a low/high pain tolerance)



If I get upset or distressed, the best way you can help is by: (e.g. play my favorite music)



How I cope with medical procedures: (e.g. how I usually react to injections, IV's, physical examinations, x-rays, oxygen therapy ---also note procedures never experienced before or in recent years)



My mobility needs are: (e.g. whether I can transfer independently, devices I use, pressure relief needed)



When getting washed and dressed, you may assist me by:



When drinking or eating, you may assist me by:



My favorite foods and drinks are:



I do not like to eat or drink the following:



I am very sensitive to: (specific sights, sounds, odors, textures/fabric, etc. that I really dislike, e.g. fluorescent lights, thunderstorms, bleach, air freshener)



Things I like to do that will help pass the time:



How to make future/follow-up appointments easier for me:

(e.g. give me the first/last appointment of the day, allow extra time for the appointment, let me visit before my appointment, give information to my caregiver, etc.)



