



HEALTH & DISABILITY COMMISSIONER  
TE TOIHAU HAUORA, HAUĀTANGA

# My Health Passport



**Please ensure I take My Health Passport  
with me when I leave.**

Date of Completion \_\_\_\_\_

Updated information is inside back cover of this booklet:

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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**First Name:**

**Last Name:**

**I like to be known as:**

### Notes for person completing the "My Health Passport"

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

### Notes for medical and support staff:

- If you are involved with my care and support, please read this document.
- This is not my Medical Record. This document gives information about:
  - Things you MUST know about me (Section A)
  - Things that are important to me (Section B)
  - Other useful information (Section C)
- This document stays with me in hospital. Please ensure I take it with me when I leave.

**Review your information when daylight saving occurs, or earlier if change occurs.**

## 1. Personal Details

Photo of you

a. NHI number:

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b. Ethnicity:

\_\_\_\_\_

c. Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d. Telephone:

\_\_\_\_\_

Mobile:

\_\_\_\_\_

e. Email:

\_\_\_\_\_

f. Preferred method of Contact:

\_\_\_\_\_

g. I have a disability alert: Yes

No

(A disability alert is a note on your medical records)

h. My GP:

\_\_\_\_\_

Practice:

\_\_\_\_\_

Telephone:

\_\_\_\_\_

Mobile:

\_\_\_\_\_

Email:

\_\_\_\_\_

Fax:

\_\_\_\_\_

i. Any dependents:

Yes

No

\_\_\_\_\_

(e.g. pets, children at school, neighbour, family member.)

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**Section A:** These are the most important things you need to know about me.

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

(You may choose to write about your impairment or other health conditions *e.g. I have cerebral palsy, I have epilepsy and my seizures vary from mild to strong.*)

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### 3. Communication

a. My preferred language: \_\_\_\_\_

b. I can also use: \_\_\_\_\_ language/s

c. I need an interpreter: Yes  No

Language: \_\_\_\_\_

d. I communicate with people using: *(e.g. gestures, facial expressions, pictures, cell-phone, texting, other technology.)*

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e. What you should be aware of when communicating with me: *(e.g., face me, speak clearly, tap furniture to get my attention, ensure my hearing aid is on, tell me what you are doing, and confirm I have understood.)*

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## 4. Decision-Making

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

Yes  No

**b.** I may need assistance to make an informed decision.

Yes  No

**c.** If for some reason, I am unable to make a decision at a time when a decision needs to be made the following will apply:

**i.** I have a legal representative

Yes  No

My legal representative is: \_\_\_\_\_

Full Name: \_\_\_\_\_

Their legal relationship: *(e.g. Welfare Guardian, Enduring Power of Attorney for health and welfare.)*

\_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

**ii.** I have a list of my wishes for health care in the future:

Yes  No

Information about my wishes can be found: *(e.g. on my medical records, at home, with my GP who holds my advance directives, I have given verbal directions to my son.)*

\_\_\_\_\_

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

## 5. Important people in my life:

a. First contact person:

(Contact people can be anyone you choose, e.g. family, friend, support worker.)

Full Name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

b. Second contact person:

Full Name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

c. Any other person or agency and their contact details:

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## 6. Things to know when providing health services

a. I am in pain when: *(e.g. I tell you, I make a particular sound, I cover or hold an area of my body)*

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b. I am allergic to: *(e.g. certain medications, perfume, nuts.)*

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c. When giving me medication, please: *(e.g. put pills on a spoon, tell me what I will experience.)*

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An up to date medication list is in the back cover of this booklet.

Yes  No

d. Supplements and herbal remedies: *(e.g. I take vitamin C tablets daily.)*

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e. When examining me, please: *(e.g. tell me what you are doing, be aware of my catheter bag, lie me on my left side.)*

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f. Other things that you need to know about me when providing a health service.

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## 7. Safety and Comfort

I need help for my safety and comfort:

*(If no move to section B, page 10.)*

Yes

No

- a. Things important for my physical safety: *(e.g. raised bed rails, my seat belt, sharp objects removed from room, sustained observation.)*

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- b. Things that may upset or make me become anxious are: *(e.g. bright lights, loud noise, lack of information.)*

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- c. You would know that I am anxious or stressed when: *(e.g. I avoid eye contact, I bite myself, I cry, I bang objects.)*

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- d. Things you could do to make me feel more in control and comfortable: *(e.g. play soft music, take me out for a walk, give me a task.)*

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**Section B:** Things that are important to me.**8. Moving Around**

I need help to move around:

*(If no move to next question page 11.)*

Yes  No

a. I move around using: *(e.g. A mobility aid, I need a hoist for transfers, I have a guide dog.)*

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b. If you are assisting me you need to know: *(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.)*

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## 9. Daily Activities

I may need help with some daily activities:

Yes

No

*(If no move to section C, page 12.)*

- a.** Using the toilet: *(e.g. I need help with buttons and zips.)*

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- b.** Washing/Taking a shower: *(e.g. I need help to dry myself, wash my hair.)*

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- c.** Grooming & personal hygiene: *(e.g. I need help brushing my hair, using a toothbrush.)*

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- d.** Dressing and undressing: *(e.g. I need help with buttons, I can't put on shoes.)*

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- e.** Eating and drinking: *(e.g. tell me what is in the food, I need a straw for all fluid, I need food in bite size pieces, food has to be soft and moist.)*

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- f.** Sleeping: *(e.g. I have sleep aid medication, I need water before I sleep, I need the light on.)*

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**Section C:** Other useful information.

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

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b. I do not like: *(e.g. certain food, dark rooms.)*

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

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d. My cultural needs: *(e.g. I require a woman doctor, where possible I need a family member with me at all times.)*

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e. Other information: *(e.g. tell me when you bring me food, and what is in it.)*

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## Acknowledgements:

'My Health Passport' is based on original work titled 'This is my Hospital Passport' by Wandsworth Community Disability Team, United Kingdom.

Thank you to everyone who has been involved in the development of the second generation of New Zealand's 'My Health Passport' including People First for the development of the easy-read version, and the Wellington Region DHBs Disability Responsiveness Team working group.

The first generation of 'My Health Passport' was completed in 2011 by Samantha Dalwood, Disability Advisor for Waitemata District Health Board, and Hemant Thakkar, former Disability Initiatives Manager for the Health and Disability Commissioner, along with the input and support of many others.

## Disclaimer:

The Health and Disability Commissioner and the Capital & Coast, Hutt Valley and Wairarapa District Health Boards make this health passport template available as a guide only and accept no responsibility for the accuracy of the information completed in the "My Health Passport".

This second generation version entitled "My Health Passport" replaces any past versions of the "Health Passport" still in circulation.







HEALTH & DISABILITY COMMISSIONER  
TE TOIHAU HAUORA, HAUĀTANGA

**This Passport stays with me in hospital.  
Please ensure I take it with me when I leave.**

To provide feedback on 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](mailto:healthpassport@hdc.org.nz)

Website: [www.hdc.org.nz](http://www.hdc.org.nz)