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Click here to enter text.



Date of completion:

Click here to enter text.

Updated information is inside the back cover of this booklet: *(Tick either Yes or No)*

YES  NO

**First name** Click here to enter text.

**Last name** Click here to enter text.

**I like to be** Click here to enter text.

**known as**

**Notes for the person completing My Health Passport**

Completing your Health Passport is optional. You may decide how much information you want to give under each section and may choose not to complete some sections of your 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

— Things that are important to me

— Other useful information

• This document stays with me in hospital. Please ensure I take it with me when I leave.

**1. Personal details**



a. National Health Index (NHI):

Click here to enter text.

|  |  |  |
| --- | --- | --- |
| b. | Ethnicity: | Click here to enter text. |
| c. | Address: | Click here to enter text. |

d. Telephone: Click here to enter text.

Mobile: Click here to enter text.

e. Email: Click here to enter text.

f. Preferred method of contact: Click here to enter text.

g. I have a disability alert:  YES  NO

A disability alert is a note on your medical records.

h. My General Practitioner (GP): Click here to enter text.

Practice: Click here to enter text.

Telephone: Click here to enter text.

Mobile: Click here to enter text.

Email: Click here to enter text.

i. Any dependents:  YES  NO

eg, pets, children, neighbour, family member.

Describe: Click here to enter text.

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

You may choose to write about your impairment or other health conditions —

eg, I have cerebral palsy, I have epilepsy and my seizures vary from mild to strong.

* Click here to enter text.
* Click here to enter text.
* Click here to enter text.
* Click here to enter text.

**3. Communication**

a. My preferred language: Click here to enter text.

b. I can also use: Click here to enter text. language/s.

c. I need an interpreter:  YES  NO

Language: Click here to enter text.

d. I communicate with people using — eg, gestures, facial expressions, pictures, telephone, texting, other technology.

Click here to enter text.

e. What you should be aware of when communicating with me — eg, 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.

Click here to enter text.

**4. Decision-making**

If 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.

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: Click here to enter text.

Full name: Click here to enter text.

Their legal relationship — eg, welfare guardian, enduring power of attorney for health and welfare.

Click here to enter text.

Telephone: Click here to enter text. Mobile: Click here to enter text.

Email: Click here to enter text.

ii. I have a list of my wishes for health care in the future:  YES  NO

Information about my wishes can be found — eg, on my medical records, at home, with my GP who holds my advance directives, I have given verbal directives to my son.

Click here to enter text.

**5. Important people in my life**

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

a. First contact person:

Contact people can be anyone you choose, eg, family, whānau, friend, support worker.

Full name: Click here to enter text.

Relationship to me: Click here to enter text.

Telephone: Click here to enter text. Mobile: Click here to enter text.

Email: Click here to enter text.

b. Second contact person:

Full name: Click here to enter text.

Relationship to me: Click here to enter text.

Telephone: Click here to enter text. Mobile: Click here to enter text.

Email: Click here to enter text.

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

Click here to enter text.

**6. Things to know when providing health services**

a. I am in pain when — eg, I tell you, I make a particular sound, I cover or hold an area of my body.

Click here to enter text.

b. I am allergic to — eg, certain medications, perfume, nuts.

Click here to enter text.

c. When giving me medication, please — eg, put pills on a spoon, tell me what

I will experience.

Click here to enter text.

An up-to-date medication list is in the back cover of this booklet.  
 YES  NO

d. Supplements and herbal remedies — eg, I take vitamin C tablets daily.

Click here to enter text.

e. When examining me, please — eg, tell me what you are doing, be aware of my catheter bag, lie me on my left side.

Click here to enter text.

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

Click here to enter text.

**7. Safety and comfort**

I need assistance for my safety and comfort  YES  NO

If no, move to page 11.

a. Things important for my physical safety — eg, raised bed rails, my seat belt, sharp objects removed from room, sustained observation.

Click here to enter text.

b. Things that may upset me or make me become anxious are — eg, bright lights, loud noise, lack of information.

Click here to enter text.

c. You would know that I am anxious or stressed when — eg, I avoid eye contact, I bite myself, I cry, I bang objects.

Click here to enter text.

d. Things you could do to make me feel more in control and comfortable —

eg, play soft music, take me out for a walk, give me a task.

Click here to enter text.

**8. Moving around**

I need assistance to move around  YES  NO

If no, move to page 12.

a. I move around using — eg, a mobility aid, I need a hoist for transfers, I have a guide dog.

Click here to enter text.

b. If you are assisting me you need to know — eg, roll me on one side when assisting 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.

Click here to enter text.

**9. Daily activities**

I may need assistance with some daily activities  YES  NO

If no, move to page 13.

a. Using the toilet — eg, I need assistance with buttons and zips.

Click here to enter text.

b. Washing/taking a shower — eg, I need assistance to dry myself, wash my hair.

Click here to enter text.

c. Grooming & personal hygiene — eg, I need assistance to brush my hair, to use a toothbrush.

Click here to enter text.

d. Dressing and undressing — eg, I need assistance with buttons, I can’t put on shoes.

Click here to enter text.

e. Eating and drinking — eg, tell me what is in the food, I need a straw for all fluid, I need food in bite-sized pieces, food must be soft and moist.

Click here to enter text.

f. Sleeping — eg, I have sleep aid medication, I need water before I sleep, I need the light on.

Click here to enter text.

**10. Other helpful information**

a. I like — eg, music, routines.

Click here to enter text.

b. I do not like — eg, certain food, dark rooms.

Click here to enter text.

c. My religious/spiritual needs — eg, karakia/prayers, Halal food.

Click here to enter text.

d. My cultural needs — eg, I require a woman doctor, where possible I need a family member with me at all times.

Click here to enter text.

e. Other information — eg, tell me when you bring me food, and what is in it.

Click here to enter text.

**Acknowledgements:**

This document is based on original work called ‘This is my

Hospital Passport’ by the Wandsworth Community Disability Team, United Kingdom.

Thank you to everyone who has been involved in developing

New Zealand’s My Health Passport.

**Disclaimer:**

The Health and Disability Commissioner makes the My Health Passport template available as a guide only, and accepts no responsibility for

the accuracy of the completed information.

**Notes:**

Click here to enter text.

HDC 
Health and Disability Commissioner 
Te Toihau Hauora, Hauātanga
 
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**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**

Email: [**healthpassport@hdc.org.nz**](mailto:healthpassport@hdc.org.nz)

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

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