MY HEALTHCARE PASSPORT

NAME: I LIKE TO BE CALLED:

BIRTHDATE: AGE:

THE PEOPLE WHO KNOW ME WELL AND SUPPORT ME:

EMERGENCY PHONE NUMBER:

PRIMARY PHYSICIAN: PHARMACY:

SPECIAL ALERTS:

MY DIAGNOSES/MEDICAL HISTORY:

DESCRIPTION OF MY BASELINE/WHEN I AM AT MY HEALTHIEST:

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ABOUT ME

YOU CAN TELL THAT SOMETHING IS WRONG:

HOW I SHOW/MEASURE PAIN:

YOU CAN HELP ME FEEL COMFORTABLE BY:

STRATEGIES FOR SUCCESS:

SENSITIVITIES/TRIGGERS:

BEHAVIOR CHALLENGES:

SENSORY NEEDS/TOOLS:

HOW TO KEEP ME SAFE:

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NAME: _____

DAILY LIFE

THINGS THAT I ENJOY/HELP TO PASS THE TIME:

MY DREAMS AND GOALS:

LEARNING STRENGTHS AND CHALLENGES:

MOBILITY NEEDS:

WASHING NEEDS:

DRESSING NEEDS:

HOW I COMMUNICATE:

EATING/DRINKING NEEDS AND/OR FEEDING REGIMEN:

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MEDICAL

CHALLENGES WITH MEDICAL PROCEDURES AND WHAT HELPS:

SPECIALISTS I REGULARLY SEE:

CURRENT THERAPIES:

CURRENT MEDICATIONS:

MEDICINES THAT I'VE TRIED AND AM ALLERGIC TO OR THAT DON'T WORK FOR ME AND WHY:

HOW I TAKE MY MEDICATIONS:

ADDITIONAL INFORMATION

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NAME: _____