Digital Editable/Printer-Friendly Edition

Queensland Health

Julian's Key

Health Passport

Name:

SEE ME. HEAR ME. RESPECT ME.

Queensland Government

This Health Passport includes important details about me to help healthcare staff understand my needs.

I will do my best to update my details every year, or as required.

I will take this with me when I go to hospital or community health services.

Please return it to me, or my carer.

Contents

Back to Contents

Summary

My name is:

Click or paste your photo here

Important things to know about me:

(e.g., what disabilities I live with, how I make decisions, contact number for emergencies, my preferred communication method, things that might make me feel anxious or nervous and what helps calm me)

Completed by:

Date completed: / / 2 0

*Please ask me if anything has changed.

Back to Contents

Things I will bring

This list helps me or my carer remember what to bring to the hospital or community health services.

My cards:

- ☐ Medicare
- ☐ Private Health
- ☐ Concession
- ☐ Department of Veteran Affairs (DVA)
- ☐ Other: _____

My documents:

- ☐ Advance Health Directive
- ☐ Power of Attorney
- ☐ Advance Care Plan
- ☐ Statement of Choices
- ☐ Order from Queensland Civil and Administration Tribunal (QCAT)
- ☐ Positive Behaviour Support Plan
- ☐ Aged Care Behaviour Support Plan
- ☐ National Disability Insurance Scheme (NDIS) Plan
- ☐ National Injury Insurance Scheme (NIISQ) MyPlan
- ☐ Other: _____

My personal items:

(e.g., wallet, medication, my comfort items, things that help reduce my anxiety)

*See page 15 for more details.

Back to Contents

My personal information

My details:

First name:

Last name:

I like to be known as:

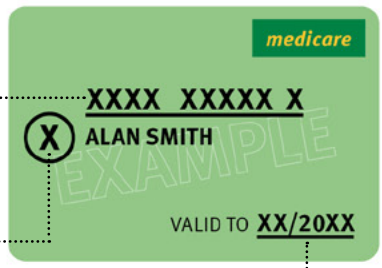
Date of birth: / /

Medicare:

Number:

Reference number:

Expiry date: / 2 0



Medicare number

Medicare reference number

Expiry date

My contact details:

Address:

Suburb:

State:

Postcode:

Phone number:

Email address:

Back to Contents

My personal information

Preferred contact method:

◯ Phone ◯ Text ◯ Email ◯ Post

◯ Other:

My next of kin:

First name:

Last name:

Phone number:

Relationship to me:

National Disability Insurance Scheme (NDIS):

I am an NDIS participant:

◯ Yes ◯ No ◯ Prefer not to say

My NDIS participant number is:

I have an NDIS plan:

◯ Yes ◯ No ◯ Not applicable

Back to Contents

My personal information

My preferred language:

My cultural identity:

- ○ Aboriginal
- ○ Torres Strait Islander
- ○ Aboriginal and Torres Strait Islander
- ○ CALD (Culturally and Linguistically Diverse)
- ○ Prefer not to say

My traditional country:

My cultural background:

(e.g., my spiritual beliefs, cultural ways of healing, yarning circle, important things to me)

*See page 9 for more details.

Back to Contents

My personal information

Gender I identify with:

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to say
- ◯ Other: _____

My pronouns:

- ◯ She/her
- ◯ He/him
- ◯ They/them
- ◯ Prefer not to say
- ◯ Other: _____

My gender assigned:

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to say
- ◯ Other: _____

Other information about my gender identity:

_____

Back to Contents

About me

What makes my day:

(e.g., a hot cup of tea, going for a walk, a favourite food, a daily routine, company of others, attending community group, my place of work)

Who my loved ones are:

(e.g., marriage/relationships, family, close friends, animals/pets)

Things I am proud of and like to talk about:

(e.g., new skill, career, occupations, community roles, favourite movie, cooking)

Back to Contents

My disability

Identified disabilities:

- ◯ Developmental delay or learning challenges
- ◯ Specific learning challenges
- ◯ Physical disability
- ◯ Blind/Low vision
- ◯ Invisible disability
- ◯ Intellectual disability
- ◯ Acquired brain injury
- ◯ Neurological disability
- ◯ Hard of hearing
- ◯ Psychosocial disability
- ◯ Communication impairment
- ◯ Autism or Neurodivergence
- ◯ Deaf
- ◯ Dementia
- ◯ Genetic disorder
- ◯ Anxiety
- ◯ Other:

More information about my disability:

My disability

Where I live:

- ◯ In private accommodation
- ◯ In an aged care home
- ◯ In supported accommodation
- ◯ In public housing
- ◯ Other: _____

Who I live with:

- ◯ I live independently
- ◯ I live with my partner or family
- ◯ I live with other people (not family)
- ◯ I live with a carer
- ◯ Other: _____

People who depend on me:

- ◯ Children
- ◯ Pets
- ◯ Friends
- ◯ Co-workers
- ◯ Elderly parents
- ◯ Spouse or partner
- ◯ Other: _____

How I communicate

My communication may change depending on how I am feeling, the environment or my stress levels.

I usually communicate using:

- ◯ Spoken communication
- ◯ Body language or facial expressions
- ◯ A person of my choice (known communication partner)
- ◯ Sign language
- ◯ Gesture
- ◯ Changes in behaviour
- ◯ Alternative augmentative communication (AAC)
- ◯ Other: _____

More information about my communication:

How I communicate

When communicating with me, please ensure I have access to:

- ◯ Hearing aids
- ◯ Computer
- ◯ Contact lenses
- ◯ Smart phone
- ◯ Glasses
- ◯ Tablet

◯ **Voice equipment**
(e.g., text-to-voice, voice-to-text, device program details, electronic applications)

◯ **Sensory items**
(e.g., noise cancelling headphones, weighted objects, fidget spinner)

◯ **Visual supports**
(e.g., magnifying devices, communication board, pictures, letter board, symbols)

When communicating with me, please engage my:

- ◯ Known communication partner:
- ◯ Interpreter:

How I communicate

I feel respected when you:

- ◯ Speak directly to me
- ◯ Use my expertise about myself
- ◯ Involve me in discussion
- ◯ Use my support network's expertise
- ◯ Give me time to respond
- ◯ Use my communication style
- ◯ Support my ability to make decisions
- ◯ Other: _____

This helps me understand you:

- ◯ Speak slowly
- ◯ Taking time to tell me
- ◯ Making eye contact
- ◯ Using real life objects
- ◯ Giving me a demonstration
- ◯ Giving me time to respond
- ◯ Using short plain sentences
- ◯ Giving me options
- ◯ Using visuals, diagrams or pictures
- ◯ Sticking to one topic at a time
- ◯ A quiet calm environment
- ◯ Other: _____

Other important things about my communication:

(e.g., checking that I have understood, ensuring my iPad is charged)

My support needs

Please involve me and support me in decision-making.

About my decision-making:

- ◯ I usually make my healthcare decisions by myself
- ◯ I need support to make my healthcare decisions

I use these supports to help me make decisions:

(e.g., mother, father, spouse or partner, family member, carer, service provider)

I have these legal documents:

- ◯ Power of Attorney
- ◯ Advance Health Directive
- ◯ Statement of Choices
- ◯ Order from QCAT
- ◯ Other:

Day-to-day support:

- ◯ I need support to participate in all of my day-to-day activities
- ◯ I need a little daily support, but I am mostly independent
- ◯ I can do some activities, but I need someone with me at all times
- ◯ I live independently, but I need occasional support
- ◯ I need some support, but I can be left alone
- ◯ I am independent

*See pages 12 or 16 for more details.

Adjustments I need

A reasonable adjustment is a change to how something is done. It makes it easier for people with disability to access healthcare.

Reasonable adjustments I may need in hospital:

(e.g., ability for my carer to stay with me beyond regular visiting hours, ability for my carer to continue to assist with cares, access to low sensory environment, support from First Nations health liaison officer)

Reasonable adjustments I may need in community healthcare:

(e.g., longer appointment times, written information, guidance from family or support network to make decisions, interpreter, quiet place to wait)

My medical history

This information was accurate at the time my health passport was completed. Please ask me if anything has changed.

I have allergies or adverse reactions:

◯ Yes ◯ No ◯ Unsure

If yes, please provide more information:

(e.g., what you are allergic to, what happens to you)

I have difficulty eating, drinking or swallowing:

◯ Yes ◯ No ◯ Unsure

If yes, please provide more information:

(e.g., dysphagia, assistance with eating)

I am on modified diet and drinks:

◯ Yes ◯ No ◯ Unsure

My medical history

My diet is:

- ◯ Regular
- ◯ Minced and moist
- ◯ Easy to chew
- ◯ Pureed
- ◯ Soft and bite-sized

My drinks are:

- ◯ Thin
- ◯ Moderately thick
- ◯ Slightly thick
- ◯ Extremely thick
- ◯ Mildly thick

I have dentures:

- ◯ Yes
- ◯ No

If yes, please provide more information:

(e.g., the type of denture, are these metal or plastic, how many pieces, any diagnosed conditions such as severe periodontitis/recurrent oral ulcers)

*See pages 29 for more details.

My medical history

My medical conditions:

(e.g., heart, breathing, diabetes, high blood pressure, depression, anxiety)

My medical history and treatment plan:

(e.g., major surgeries, medical interventions and current care plans)

My medical history

I take medication/s:

◯ Yes ◯ No ◯ Unsure

You will find information about my medication by:

◯ Asking me ◯ Asking my carer ◯ Reading the attachment

◯ Other:

How best to perform a medical assessment with me:

(e.g., enable my support person to be with me, explain what will happen prior, provide visuals or diagrams, quiet environment)

*See pages 12 or 15 for more details.

My pain

What pain I live with:

(e.g., I live with chronic arthritis in my left hand)

What helps me manage my pain:

(e.g., my regular pain medication, weekly appointment with my physiotherapist)

What makes my pain worse:

(e.g., transferring from my wheel chair to my shower chair)

My pain

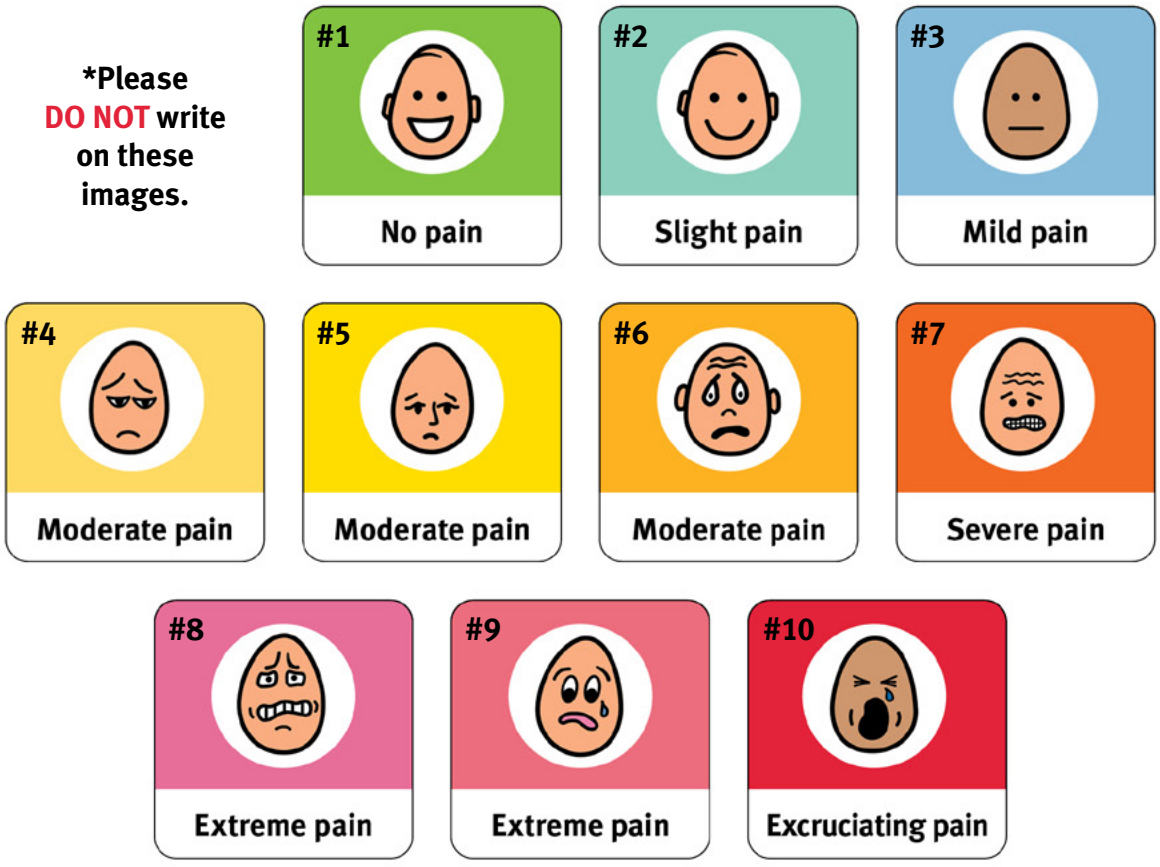
How to know I am in pain:

(e.g., when I rock back and forth in my chair it usually means I am uncomfortable or distressed which can be due to pain)

How much pain I am in:

☐ I will use this visual aid (or my own) to show how much pain I am in

***Please DO NOT write on these images.**



☐ Other ways I will let you know my pain levels:

My pain

Where my pain is:

◯ I will use this visual aid (or my own) to show where my pain is

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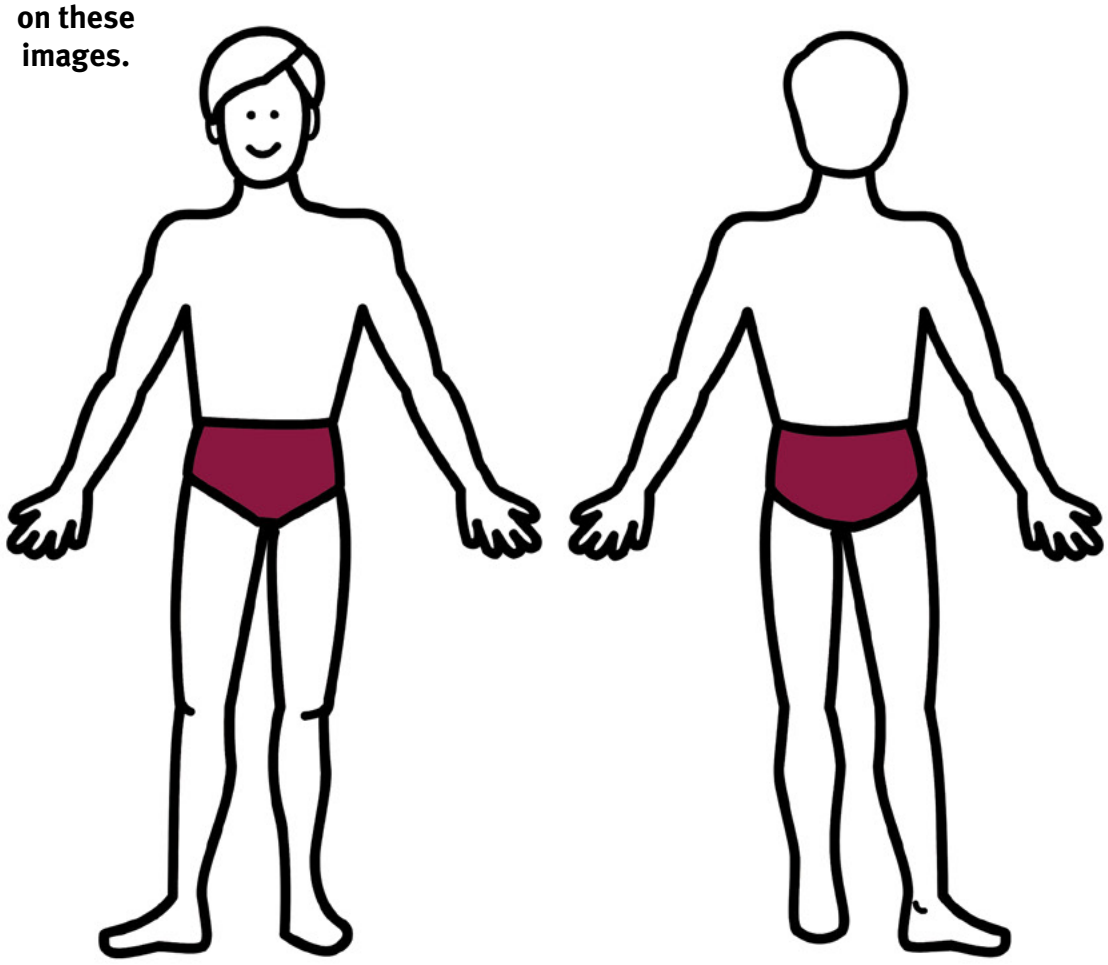

Front Back

◯ Other ways I will let you know where my pain is:

My pain

Where my pain is:

○ I will use this visual aid (or my own) to show where my pain is

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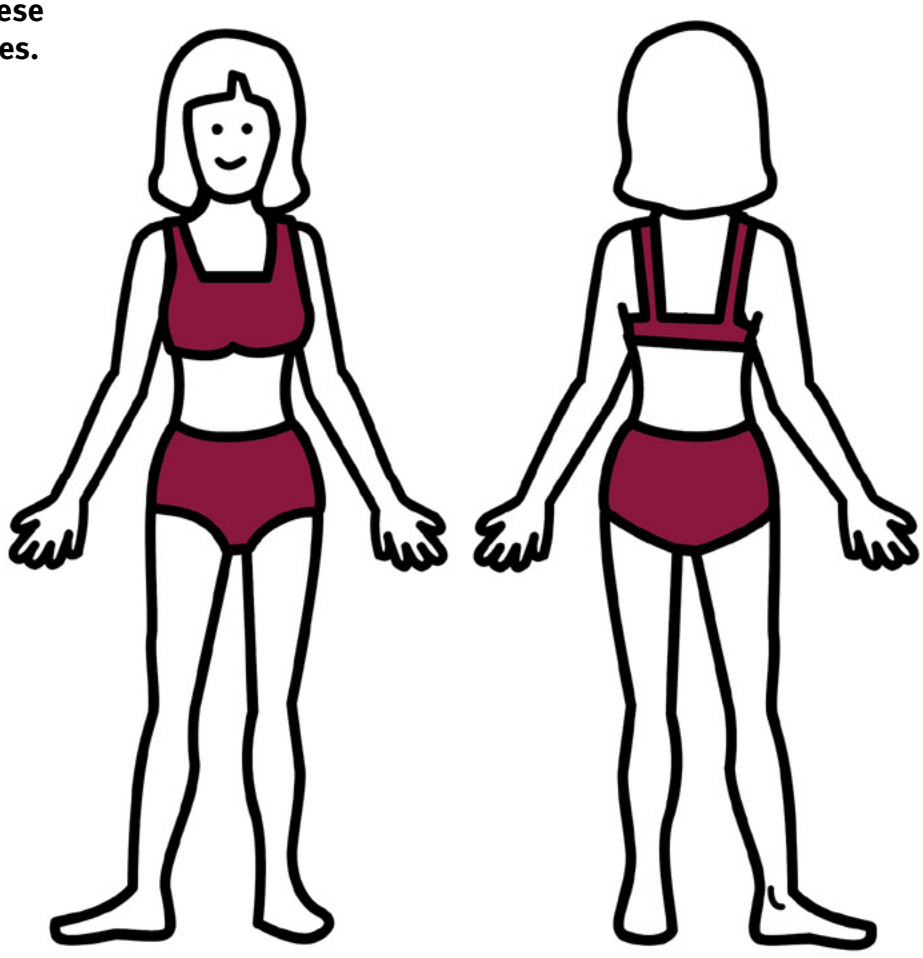


Front Back

○ Other ways I will let you know where my pain is:

My feelings

How I am feeling today:

○ I will use this visual aid (or my own) to show how I am feeling

*Please DO NOT write on these images.

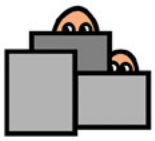

Happy


Excited


Interested


Angry


Frustrated


Shy


Worried


Sad


Scared


Too loud


Too bright

Stop

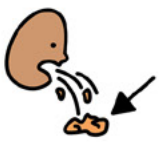

Hot


Cold


That hurts


Diarrhoea


Constipated

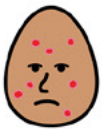

Vomit


Headache

Back to Contents

My feelings

*Please **DO NOT** write on these images.


Allergic


Dizzy

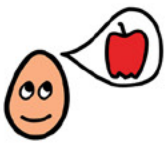

Sick

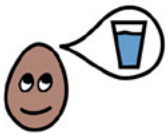

Burnt


Bleeding


Broken


Seizure/fit


Hungry


Thirsty


Toilet


Adjust bed


Eyes


Mouth


Ear


Arm


Leg


Feet


Stomach


Back

◯ Other ways I will let you know how I am feeling:

My feelings

How my feelings can change and how you can support me.

These things keep me calm and happy:

(e.g., being talked to softly, background music, having my mum with me)

What I look like when I am calm and happy:

(e.g., sometimes I grunt and groan and rock back and forth)

My feelings

These things make me frustrated and angry:

(e.g., being left alone, being touched on the shoulder)

What I look like when I am frustrated and angry:

(e.g., I may start pacing, I may tap a surface)

What you can do to help me:

(e.g., adjust lighting, reduce noise, offer weighted blanket)

My care needs

How to keep me safe in hospital:

(e.g., bed rails, support with challenging behaviour)

How I take my regular medications:

(e.g., webster pack, remind me to take, pill box)

How I move:

(e.g., walk with assistance, I use a mobility aid, with pain management support)

My care needs

How I use the toilet:

(e.g., continence aids, reminders, toilet assistance, help with buttons/zips)

How I eat:

(e.g., food cut up, remind me to eat, pureed, help with eating)

How I drink:

(e.g., small amounts, remind me to drink, thickened fluids, straw)

My care needs

How I do my personal care:

(e.g., I use an electric toothbrush, I have prescribed toothpaste,
my saliva management, I need help to brush my hair, dressing and washing)

How I sleep:

(e.g., my sleep pattern, sleep medication, I need water before I sleep, I need the light on)

Other care needs I would like to share:

Back to Contents

My support network

My doctor or general practitioner (GP):

(e.g., your GP is usually the first person you see if you have a health concern)

Full name:

Practice name:

Phone number:

My other services or specialists:

(e.g., medical specialist, speech therapist, physiotherapist, occupational therapist, dentist, local pharmacist)

Full name:

Occupation:

Phone number:

Full name:

Occupation:

Phone number:

Back to Contents

My support network

Full name:

Occupation:

Phone number:

Full name:

Occupation:

Phone number:

Full name:

Occupation:

Phone number:

Full name:

Occupation:

Phone number:

My support network

These people support my health and wellbeing:

(e.g., family, friends, disability support worker, support coordinator, support planner)

Full name:

Relationship to you:

Their role in your care:

Phone number:

Full name:

Relationship to you:

Their role in your care:

Phone number:

Full name:

Relationship to you:

Their role in your care:

Phone number:

Back to Contents

My support network

Full name:

Relationship to you:

Their role in your care:

Phone number:

Full name:

Relationship to you:

Their role in your care:

Phone number:

Full name:

Relationship to you:

Their role in your care:

Phone number:

Back to Contents

Other things I want to share

Other things:

(e.g., other information I think may be useful)

Queensland Health

Julian's Key

Health Passport

Julian's Key Health Passport

SC2400860 8/11/24

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Queensland Government