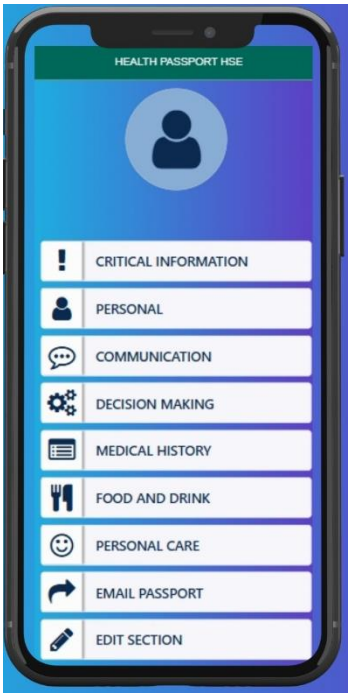
Health Passport Printed Version



- This is the **printed version** of the Health Passport (HSE) App. It is **not** meant to be filled in on a digital device.
- There is a Guidance document and Video to help you fill in this Health Passport.
- The latest information can be found on the Health Passport HSE webpage.
- If you have access to a digital device, it is preferable to use the Health Passport (HSE) App which can be downloaded in the App Store.
- Please keep this safe in your possession.
- Make sure your handwriting is clear.

Note to Clinicians – Please return this document to the person once you have obtained all relevant information

Critical Information

Critical Information about me:

General

Name: _____

Date of birth: _____

I like to be called: _____

Contact number: _____

PPS Number: _____

Address: _____

Medical card number: _____

_____

Religion: _____

_____

GP

GP Name: _____

GP Contact number: _____

Family

Family Contact Name: _____

Family Contact number: _____

Carer

Service provider name: _____

Service provider contact number:

_____

Pharmacy

Pharmacist name: _____

Pharmacist contact number:

_____

Communication

How to reassure me when examining or caring for me:

These are supports I need to communicate:

My eyesight:

My hearing:

What I do if I am afraid or worried:

How you can support me if I am afraid or worried:

Things I do if I am sore or in pain:

Things that I do or use to keep safe:

Things I like (what makes me happy, things I like to do, see or talk about):

Things I do not like (what upsets me, things I do not like to do, see or talk about)

Decision Making

What supports I need to make decisions:

People who support my decision making:

Any relevant contact information for decision making support:

Do you have an advanced healthcare directive?:

Medical History

Other medical professionals involved in your care (name, phone no.):

Things I am allergic to:

Known medical and surgical history and diagnoses:

Support I need to take medication:

Medications: attach my medicines list

Food and Drink

Fluid thickened? If yes, grade 0 to 4: _____

Thickener used: _____

Modified diet? If yes consistency needed: _____

Foods I like:

Foods I dislike:

Support I need to eat and drink:

Personal Care

Support I need for toileting:

Support I need for showering:

Support I need for getting dressed:

Support I need with moving:

Support I need with my oral or dental care:

Support I need for breathing:

Support I need for sleeping:

Completed by: _____ **Date:** _____

Review Date: _____