**COVID 19 Hospital Communication Passport**

This Hospital Communication Passport helps you to understand me and how to meet my needs whilst providing my care and treatment and supporting my dignity and safety. Abiding with UN Convention on the Rights of Persons with Disabilities, UN Convention on the Rights of the Child.

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| **My Name: My Date of Birth:** |
| **My Home Address**  **Post Code:** | Insert Photo |
| **My Medicare Number**  |
| **My Health Insurance Number** (if applicable) |
| **My GP/Doctors Contact details**  |
|  |
| **Next of kin / My representative name:****Contact Number:** **Relationship to me: Language they speak:**  |
|  |

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| **MEDICAL INFORMATION:****Allergies**:**Pre -existing medical conditions:****Current Medication:** (Enter details of all medications name/dosage and frequency/andwhat medication is for)**How I take it** (example: liquid /crushed tablet / through a syringe in my mouth / with food / other) **Medical intervention, how to take my blood, give injections etc…****Normal respiratory function** **YES/NO Swallow normal** **Yes/ No****Any airways issues:**   |
|  **Disabilities/impairments/diagnosis****…………………………………………………………………………………………………………………………****…………………………………………………………………………………………………………………………****…………………………………………………………………………………………………………………………****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****How best to support me and to keep me safe** I am Autistic                              I am Epileptic                    I have a epilepsy plan I have a behaviour plan             I have a feeding planOther (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**COMMUNICATION NEEDS:** **I communicate by …………………………………………………………………………………………………** **How I say Yes or No: ……………………………………………………………………………………………..****To help me understand I need:………………………………………………………………………………….****When I am in pain you will know because I :**(Example: become quite, start tapping my head, ears, tummy, become vocal, unsettled, start pointing) **…………………………………………………………………………………………………………………………****When I am upset or when I am worried I will …………………………………………………………………** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****SENSORY NEEDS** **I can hear: …………………………………………………………………………………………………………..****I can see:  ..………………………………………………………………………………………………………….****I can feel: ……………………………………………………………………………………………………………****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****PHYSICAL NEEDS:** **My physical disability/needs are ………………………………………………………………………………..****I need support with the following:**Dressing and washing                  Eating and drinking Toileting             Seating and mobility  **Normal diet/ specialist diet e.g. purée/ tube fed:……………………………………………………………..****I need the following help to eat:…………………………………………………………………………………****I need the following help to drink:………………………………………………………………………………** **Level of support I need with my personal care:  1:1,  2:1**  |

This resource has been produced by Include Me TOO

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