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HEALTH RISK SCREENING TOOL

My Health Passport

This document has important information so you can get to know me and better support me when I am receiving medical, dental, or other care. Please keep this information where others can easily reference it, and please **READ THIS BEFORE** trying to help me with care or treatment.

Demographic Information

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

DOB: _____ Gender: _____ Race: _____ Marital Status: -- _____

Insurance info: _____ Other ID Number: _____

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

Psychiatrist:

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

Dentist:

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

Preferred Hospital: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

Family contact (and/or person who supports my decision-making):

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

Emergency contact:

Name: _____ Phone: _____

Address: _____ City: _____ State: -- Zip: _____

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Important Clinical Information

Diagnoses:

Medications and dosages:

Medication allergies or adverse reactions and type of reactions:

Food allergies and type of reaction:

When I experience pain, I often: (describe behavior, etc.)

Usual manner and level of mobility: (describe method, usual gait or pattern of movement & needed supports)

My diet is: (type and texture)

The type of assistance I need when eating:

The type of assistance I need when drinking:

Most recent weight (and date):

Weight over past 6 months: (list monthly weights and dates measured)

I take medications best in this form: (liquids, pills, mixed in pudding, etc.)

How I use the toilet: (continence level, assistance, aids or products needed)

My usual bowel movement pattern:

Name: _____

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Important Information About Communication

I communicate best using: (words, gestures, sign language, behaviors etc.)

Hearing: (normal, somewhat impaired, fully impaired, etc.)

Vision (normal, somewhat impaired, fully impaired, etc.)

Important Social Information

My friends and people who know me describe me as: (fun, likeable, smart, good at puzzles etc.)

I Like:

When I like something, I express it by:

I dislike:

When I dislike something, I express it by:

The best way to communicate with me is:

My usual sleep pattern is:

My favorite activities are:

I usually interact with friends this way: (friendly, smiles, anger, fear etc.)

I usually interact with strangers this way: (friendly, smiles, anger, fear etc.)

Name: _____

When I'm angry, I sometimes:

When upset, the best way to help me calm down is:

Things that I am sensitive to include: (specific sights, sounds, odors, textures/fabric, etc.)

Things that help me pass the time:

Health Risk Screening Tool Scores

Overall Health Care Level: _____

- Levels 1 and 2 low risk
- Levels 3 and 4 moderate risk
- Levels 5 and 6 high risk

Date of most recent scoring: _____

Individual scores (Attach a print-out of the scoring summary)

Additional information:

Name: _____