My Patient Passport

__________________________

Patient Name

Use this passport to record and organize your healthcare journey. It is a tool to help with communication between you and your healthcare provider.

Patient and Family Engagement leads to better health outcomes and improved safety for patients.

**Tips on how to use your patient passport**

- Please fill out this booklet with your current healthcare information. Update as your health changes, date new entries, add extra pages as needed. (You may print extra pages by going to the Prairie Mountain Health website.)
- In Section 3, write down any questions you want to ask your health care provider.
- Take it with you when you visit any of your health care providers. Keep it in a handy place.
- Instructions on how to use each area are found under the titles.
- This does not replace the Emergency Response Information Kit (ERIK), but we encourage you to use it along with your kit.
- Keep your information private. You are responsible for the privacy of information in this passport.

**Disclaimer:**
The information in your Passport is for your use only and does not replace ongoing/changing medical advice about your health. If you have questions about your health, please contact your doctor or nurse.

Date of Issue: 2017-Jan-18
Date of Revision: 2017-Mar-15
Document #: PMH1299b
Full Name: _______________________________________________________________

Home mailing address: ______________________________________________________

Home phone: _______________ Cell phone: _______________ Work phone: _______________

MB Health Number (6 digit): __________________________ PHIN Number (9 digit): __________________________

Preferred Language: _______________ Blood Type: ________

Advance Care Directive in place: ☐ Yes ☐ No  *If yes, where can it be found? __________________________

Emergency contact/next of kin:

Name: __________________________________________________________________________

Home Address: _____________________________________________________________________

Home phone: _______________ Cell phone: _______________ Work phone: _______________

Alternate Decision Maker: ☐ Same as above ☐ I do not have one

Name: __________________________________________________________________________

Home Address: _____________________________________________________________________

Home phone: _______________ Cell phone: _______________ Work phone: _______________

Existing Medical Conditions: ______________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Other medical history, I want my health care provider to know (include dates) (e.g. previous heart attack, cancer diagnosis, etc.): 

Surgical History:
List previous surgeries, where done and when:
Past blood transfusion:  □ Yes  □ No  □ Unknown

Adverse reaction to transfusion:  □ Yes  □ No  □ Unknown
*If yes, please describe: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Have you ever undergone anaesthesia?  □ Yes  □ No

□ Spinal/Epidural (freezing needle in back)
□ Local (just a part of your body was numb)
□ General (I was put to sleep)

Reaction:  □ Yes  □ No
*If yes, please describe: __________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Immunizations:

□ Flu shot (date) ______________

□ Tetanus (date) ______________

□ Other  ________________ (date) ______________
                         ________________ (date) ______________
                         ________________ (date) ______________
                         ________________ (date) ______________
Medications

Include prescriptions, over the counter medications, vitamins supplements, and essential oils.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>How Much</th>
<th>How Often</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE Drug X</td>
<td>0.5mg</td>
<td>1 pill</td>
<td>Once a day</td>
<td>Blood pressure</td>
</tr>
</tbody>
</table>

* A list of current medications can be printed off by your pharmacist.

Allergies:

<table>
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<tr>
<th>Allergic to:</th>
<th>Reaction:</th>
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</table>
Members of my health care team (Doctor, Nurse Practitioner, Home Care, Mental Health, etc.):

Name: _____________________________________________________________
Address: __________________________________________________________
Reason: ________________________________________________________________________________
Phone Number: __________________________

Name: _____________________________________________________________
Address: __________________________________________________________
Reason: ________________________________________________________________________________
Phone Number: __________________________

Name: _____________________________________________________________
Address: __________________________________________________________
Reason: ________________________________________________________________________________
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Name: _____________________________________________________________
Address: __________________________________________________________
Reason: ________________________________________________________________________________
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Name: _____________________________________________________________
Address: __________________________________________________________
Reason: ________________________________________________________________________________
Phone Number: __________________________

Consulted Specialists:

Name: _____________________________________________________________ Date: ______________________
Address: __________________________________________________________ Phone Number: __________________________
Reason: ________________________________________________________________________________

Name: _____________________________________________________________ Date: ______________________
Address: __________________________________________________________ Phone Number: __________________________
Reason: ________________________________________________________________________________

Name: _____________________________________________________________ Date: ______________________
Address: __________________________________________________________ Phone Number: __________________________
Reason: ________________________________________________________________________________

Name: _____________________________________________________________ Date: ______________________
Address: __________________________________________________________ Phone Number: __________________________
Reason: ________________________________________________________________________________

Name: _____________________________________________________________ Date: ______________________
Address: __________________________________________________________ Phone Number: __________________________
Reason: ________________________________________________________________________________

Pharmacist:

Name: _____________________________________________________________ Phone Number: __________________________
Address: __________________________________________________________
Assistive Devices (select all that apply)

Hearing Aids:  □ left  □ right
Dentures:  □ upper  □ lower  □ partial
□ Eye Glasses
□ Mobility Aide:  □ walker  □ cane  □ wheelchair
                    □ prosthetic  □ other ____________

Personal Care:

Toileting:  □ Independent  □ Assisted
Bath/Shower/Sponge:  □ Independent  □ Assisted  □ Tub with shower
                    □ Walk in shower  □ Hand held shower

Diet concerns (include difficulty chewing and swallowing, food allergies/intolerances, cultural considerations, special diets, etc.):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Other general information:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
SECTION 2:
HEALTH CARE MANAGEMENT
(What the health care provider wants me to know)

Future appointment (i.e. Home Care, Mental Health, Dietitian, Physio, Occupational Therapist, Speech Therapy, Surgeon, etc.)

Date _____________    Who ___________________________    Where ____________________________
Date _____________    Who ___________________________    Where ____________________________
Date _____________    Who ___________________________    Where ____________________________
Date _____________    Who ___________________________    Where ____________________________
Date _____________    Who ___________________________    Where ____________________________
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Date _____________    Who ___________________________    Where ____________________________
Date _____________    Who ___________________________    Where ____________________________

Additional notes or instructions:
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SECTION 3:
WHAT I WANT MY HEALTH CARE PROVIDER TO KNOW

My health care goals are (e.g. lose weight, quit smoking, control my diabetes, etc.):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Concerns or questions I wish to discuss with my health care provider:

Date: ________________________________________________________________

Concern: __________________________________________________________________

________________________________________________________________________

Outcome: __________________________________________________________________

________________________________________________________________________

Date: ________________________________________________________________

Concern: __________________________________________________________________

________________________________________________________________________

Outcome: __________________________________________________________________

________________________________________________________________________

Date: ________________________________________________________________

Concern: __________________________________________________________________

________________________________________________________________________

Outcome: __________________________________________________________________

________________________________________________________________________
Symptom Tracker

Date Started: ____________________________
Symptom: ________________________________
Changes: ________________________________
Date of Changes: ________________________

Date Started: ____________________________
Symptom: ________________________________
Changes: ________________________________
Date of Changes: ________________________

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Symptom: ________________________________
Changes: ________________________________
Date of Changes: ________________________

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Symptom: ________________________________
Changes: ________________________________
Date of Changes: ________________________

Date Started: ____________________________
Symptom: ________________________________
Changes: ________________________________
Date of Changes: ________________________
Patient’s Health Journal

*Please rate your pain/symptom on the scale included (1 is low, 10 is high)

*Use only the areas that apply to you

<table>
<thead>
<tr>
<th>Date</th>
<th>Pain/Symptom Level</th>
<th>Blood Pressure</th>
<th>Blood Sugar</th>
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<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
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<td></td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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I have better days when: ____________________________________________________________
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Patient Advocate:

A patient advocate is a person you choose to support you and act on your behalf. He or she will talk with your healthcare providers. A patient advocate cannot make their own decisions about your healthcare. Their actions on your behalf are based on your wishes.

A patient advocate agreement can help you and your advocate decide how your advocate can best provide you with the support you need.

For patient advocate information, please go to:

- It’s Safe To Ask at www.safetoask.ca and
- Manitoba Institute for Patient Safety at www.mips.ca

Health Links—Info Santé:

Health Links—Info Santé is a 24-hour, 7 days a week telephone information service staffed by registered nurses with the knowledge to provide answers over the phone to health care questions and guide you to the care you need.

Call anytime (204) 788-8200 or tool-free 1-888-315-9257.