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.

PRAIRIE MOUNTAIN HEALTH

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.

Medication Name	Strength	How Much	How Often	Reason for Taking
EXAMPLE *Drug X*	*0.5mg*	*1 pill*	*Once a day*	*Blood pressure*

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

Allergies:

Allergic to:	Reaction:

Members of my health care team (Doctor, Nurse Practitioner, Home Care, Mental Health, etc.):

Name: _____
Address: _____ Phone Number: _____
Reason: _____

Name: _____
Address: _____ Phone Number: _____
Reason: _____

Name: _____
Address: _____ Phone Number: _____
Reason: _____

Name: _____
Address: _____ Phone Number: _____
Reason: _____

Name: _____
Address: _____ Phone Number: _____
Reason: _____

Name: _____
Address: _____ Phone Number: _____
Reason: _____

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: _____

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 _____
Date _____ Who _____ Where _____
Date _____ Who _____ Where _____

Additional notes or instructions:

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: _____

Date Started: _____

Symptom: _____

Changes: _____

Date of Changes: _____

Date Started: _____

Symptom: _____

Changes: _____

Date of Changes: _____

Date Started: _____

Symptom: _____

Changes: _____

Date of Changes: _____

Date Started: _____

Symptom: _____

Changes: _____

Date of Changes: _____

Date Started: _____

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*

Date	Pain/Symptom Level Low High	Blood Pressure	Blood Sugar
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		
	1 2 3 4 5 6 7 8 9 10		

I have better days when: _____

_____

_____

_____

_____

_____

_____

_____

_____

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.