HEALTHCARE PASSPORT

A PERSON CENTERED APPROACH TO PREPARING FOR TIMES OF CRISIS/COVID-19
Creating Your Person-Centered Description and Healthcare Passport for Times of Crisis

We know that some people may have to go to the hospital or a COVID-19 Unit to get better. Sometimes people have to go alone to places where workers don’t know them.

Because crisis events can affect anyone at any time, it is helpful to plan ahead.

Our goal is to help you work on a 2-page form to tell healthcare workers about you if you have to go alone to a hospital or other healthcare facility.

The form has two pages – a front and a back:

1. **Person-Centered Description**: tells what is important to you and how to best support you while getting care in a hospital or healthcare location.

2. **Healthcare Passport**: tells brief information about your health.

This booklet has directions, examples to help you, and blank forms so you can make your own forms.

If you need help or cannot complete your own Person-Centered Description or Healthcare Passport, you can ask a trusted person who knows you well to help.

Please note: Some terms are used interchangeably in the resources to follow. For example: “Description” and “Profile;” “Directions” and “Instructions;” “Passport” and “Health Care Information.”

Lets get started on your plan!
Directions for Developing Your Person-Centered Description

If you need help or cannot complete your own Description, ask a trusted person who knows you well to help.

Tips

- Think about who will read your Description. It may be your doctor, nurse, or other healthcare worker.
- What are the most important things you want healthcare workers to know about you?
- Remember that information should be easy to understand.
- The Description should be short and take no longer than one minute to read.

How To Make A Person-Centered Description

- Look at the example Descriptions provided for ideas.
- Complete the enclosed form for your Person-Centered Description.
- Write short thoughts and focus on what is most important to you.

There Are Three Parts To Fill Out: Here are some ideas of what you might want to include. You can add your picture if you want.

1. What people like, admire, and appreciate about me
   a. Describe what you are good at and what you are most proud of.
   b. Include what people close to you say they like or admire about you.

2. Who and what is important to me – things healthcare workers need to know
   a. List people who are important to you and their phone numbers.
   b. List ways you can be a part of your health care team.
   c. List what helps you relax or sleep.
   d. List any religious or spiritual practices that help you feel at peace.
   e. List any personal items you like to have with you!
3. **How to best support me** - ways healthcare workers can help me feel comfortable  
   a. What makes you comfortable?  
   b. How do you want to take medication?  
   c. How can healthcare workers help you feel calm and safe?  
   d. How do you let people know you are in pain?  
   e. What is the best way for people to communicate with you?  
   f. Explain how people know when you are getting upset, afraid, or stressed - and how they can help.

**Directions for Developing Your Person-Centered Description**

The Healthcare Passport can help healthcare workers to provide you with good care and to follow your wishes. If you need help or cannot complete your own Healthcare Passport, you can ask a trusted person who knows you well to help.

Read through each part carefully and add your own information. Your Healthcare Passport should be short and take no longer than one minute to read.

**Your Healthcare Passport includes:**

1. Personal Information  
2. Medication List  
3. Current Risk Factors  
4. Assistive Devices and Health Conditions - may include service animal  
5. Allergies and Dietary Restrictions  
6. Current healthcare Symptoms - to be completed if needed  
7. Other Planning Documents you have completed and location

The information on the Healthcare Passport may not be complete. Full list of current medications, treatments, and/or current symptoms may be on separate form(s),
MY PERSON-CENTERED DESCRIPTION

Please call me by this name

MaryAnne Bailey

1. What people like, admire, and appreciate about me

Kind, caring, good listener, patient with people, never gives up, no nonsense

2. What is important to me

- My sister Gwendolyn & my friend Ester. Please keep them up to date about me; and keep me up to date about them.
- My faith.
- My violet plant collection.
- To know what is happening with me; don’t tell others without telling me.

3. How best to support me

- Please don’t raise your voice or repeat yourself it makes me nervous
- Give me time to answer, I know what I want to say but it can take time for it to come out.
- If I am worn out, I may not answer; if I look to the side and back at you, I have heard you.
- I don’t like to ask for help and prefer to do things myself, if I do ask it is imminently important.
- Please keep me dressed or covered; make sure everything is in place, no gaps, or openings
- Sit where I can see you

Completed by: ________________________________ Date: _____________

☑Me  □ Someone else (specify name and role): ________________________________
### COVID-19 Passport

#### Personal Information

| First Name: MaryAnne | (Nickname): | Last Name: Bailey | DOB: 8/12/1953  
| Age: 67 |
|----------------------|-------------|------------------|
| Street Address: 100 Main | City, State, Zip: Her Town, KS 66720 |
| Phone number: XXX-XXX-XXXX | Preferred Language: English |
| Emergency Contact Name and Phone/Email: Karen Green, 111-222-3333/greenk@email.com |
| Parent/Legal Representative Name and Phone/email: N/A | Communication needs: N/A |
| Insurance Information: Medicaid |
| Pharmacy Information (Most Commonly Used): Kindcare, Her Town, KS 66720 |
| Primary Care Provider/Contact Information: Dr. NotMcdreamy 111-222-3333 |
| Opthamologist: Dr. Eeyore 111-222-4444 |

#### Medications/Risk Factors

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Covid-19 Severity Risk Factors (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram (Celexa)</td>
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<tr>
<td>Diazepam (Valium)</td>
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<tr>
<td>Gabapentin (Neurontin)</td>
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<tr>
<td>Preservative Free Eye Drops</td>
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<tr>
<td>□ Long-term care resident</td>
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<tr>
<td>□ Transplant</td>
<td></td>
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<tr>
<td>□ COPD/Emphysema/Asthma</td>
<td></td>
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<tr>
<td>□ Current/Former Smoker</td>
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<tr>
<td>□ Intellectual disability</td>
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<tr>
<td>□ Neurological disorder/Cerebral Palsy</td>
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<tr>
<td>□ Heart disease</td>
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<tr>
<td>□ Corticosteroid use</td>
<td></td>
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<tr>
<td>□ Mental Illness/substance use</td>
<td></td>
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<tr>
<td>□ Cancer</td>
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<tr>
<td>□ Age 65 or over</td>
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<tr>
<td>□ Pregnant</td>
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<tr>
<td>□ Severe obesity</td>
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<tr>
<td>□ HIV/AIDS</td>
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<tr>
<td>□ Kidney disease</td>
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<tr>
<td>□ Homeless</td>
<td></td>
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<tr>
<td>□ Chronic bronchitis</td>
<td></td>
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<tr>
<td>□ Other</td>
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</tbody>
</table>

Note: Information on this form may not be complete

#### Assistive Devices/Health Conditions

| Depression |
| Cerebral Palsy Muscle Relaxant |
| Cerebral Palsy Anticonvulsant |
| Dry Eye (right) |

#### Allergies and Diet Restrictions

| No known |

#### Current Symptoms

| □ Temp. over 100.4 ° F |
| □ Dry Cough |
| □ Malaise/Fatigue |
| □ Shortness of breath |
| □ Nasal congestion |
| □ Diarrhea |
| □ Loss of smell/taste |
| □ Sore throat |
| □ Low blood oxygen |
| □ Headache |

Advanced Care Planning (check all that apply and location of document if known):

- □ HEALTH CARE DIRECTIVE OR LIVING WILL—on file at ABC Nursing Home
- □ DO NOT RESUSCITATE ORDER/DO NOT INTUBATE— on file at ABC Nursing Home
- □ POWER OF ATTORNEY FOR FINANCES
- □ PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT (POLST, MOSLT, OR POST
- □ PSYCHIATRIC ADVANCE DIRECTIVE

IMPORTANT: COVID-19 Person-Centered Description on Reverse Side
MY COVID-19 PERSON-CENTERED DE-

Please call me by this name

Teresa

1. What people like, admire, and appreciate about me

Great Sense of Humor, Kind, Friendly, Caring

2. What is important to me

My Family and Friends: I like to talk to them every day and spend time with them. I need my cellphone near me so I can call them when I need to talk.

My God: I am Catholic. When I am sick, I want to receive Communion and Sacraments. I want visits by the Priest or Lay Ministers. I also like my Rosary to be near in case I want to hold it and pray. It gives me comfort.

My Cellphone: I need it plugged in for me so that it is never out of power. Remaining on my whole food plant-based diet is important to me.

3. How best to support me

- I have Rheumatoid Arthritis (RA) and have a lot of pain. I have a very high pain tolerance. So if I ask for help for pain, I am in a lot of pain. Please trust me and give me medication that will help relieve the pain. If you cannot give me medication, please use things like hot and cold packs, aromatherapy, music and prayer.

- I do get fearful when I am in the hospital. If I am scared and anxious, I will ask a lot of questions. Please be truthful to me. If I become scared or weepy, let me speak to my family. You can also offer that I talk to a Chaplain. Preferably a Catholic Chaplain but if none is available, any caring soul would be appreciated. I am also OK with taking an anti-anxiety medication.

- When I sleep, I need my CPAP machine and some type of blanket even when it is warm in the room. It can be a sheet. I like the room dark.

- I have a lot of medical issues. My primary Doctor, Doctor Olson, knows me the best. If available, I would like you consult with her. I am also well-versed in all of my health care so please ask me anything you want. My husband Harry (phone XXX-XXX-XXXX), daughter Rose (XXX-XXX-XXXX), and son Jeff (XXX-XXX-XXXX) are also great historians of my health care. If they are not available, my sister Julie (XXX-XXX-XXXX) may be called.

Completed by: ________________________________ Date:__________________

☑ Me      □ Someone else (specify name and role): ________________________
**COVID-19 PASSPORT**

**Personal Information**

<table>
<thead>
<tr>
<th>First Name: Theresa</th>
<th>Last Name: Peterson</th>
<th>DOB: 8/12/1953</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address: 5275 South Lane</td>
<td>City, State, ZIP:</td>
<td></td>
</tr>
<tr>
<td>Phone number: XXX-XXX-XXXX</td>
<td>Deerwood, Minnesota</td>
<td>56444</td>
</tr>
<tr>
<td>Preferred Language: English</td>
<td>Emergency Contact</td>
<td></td>
</tr>
<tr>
<td>Legal Representative Name and Phone/E-mail: N/A</td>
<td>Name and Phone/Email: Harry Peterson XXX-XXX-XXXX</td>
<td></td>
</tr>
<tr>
<td>Insurance Information: Health Partners</td>
<td>Pharmacy Information (most commonly used): Guidepoint, Brainerd, MN</td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider/Contact Information: Doctor Olson, Essentia Brainerd</td>
<td>Specialty Care Providers/Contact Information: Doctor Smith, Mayo Rheumatology</td>
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</tbody>
</table>

**Medications / Risk Factors**

- **MEDICATIONS:**
  - Rosuvastatin 20 MG 1 at bedtime
  - Vitamin D 2000 U 1 tablet evening
  - Nitroglycerin 0.4 sublingual tablet PRN
  - Acetaminophen 650 MG tablet 2 tabs daily
  - Levothyroxine 75 MCG 1 day
  - Metformin 1/2 500 MG 1 a day
  - Probiotic 1 cap daily
  - Aspirin EC 81 MG 1 a day
  - Ceftriaxone 10 MG 1 a day
  - Hydrochlorothiazide 1/2 12.5 tab daily
  - Bisoprolol 5 MG daily
  - Prednisone 5 MC daily morning
  - Hydroxychloroquine 200 MG 2 times daily
  - Azathioprine 50 MG a.m. and 100 MG p.m.
  - Abatacept 125 MG/ML solution injection weekly

- **COVID-19 Severity Risk Factors (check all that apply):**
  - Long-term care resident
  - Transplant:
  - COPD/Emphysema/Asthma
  - Current/former smoker
  - Liver disease
  - Intellectual disability
  - Neurological disorder
  - Heart disease
  - Corticosteroid use
  - Mental illness/substance use

**Note:** Information on this form may not be complete

**Assistive Devices/ Health Conditions**

- **Assistive Devices:** CPAP

**Other Health:** Rheumatoid Arthritis and Rheumatoid Lung Disease, CAD with CABG 6/10/2019, hypertension, hyperthyroidism, Hyperlipidemia, GERD, Osteopenia, Sleep apnea, Vitamin D deficiency, diabetes, Immunocompromised

**Allergies and Diet Restrictions**

- **Allergies:** atorvastatin, niacin, pravastatin, propranolol, simvastatin, tetracycline

- **Diet:** Whole foods plant-based diet

**Current Symptoms**

- Temp. over 100.4°F
- Dry cough
- Malaise/Fatigue
- Shortness of Breath
- Nasal Congestion
- Diarrhea
- Loss of Smell/Taste
- Sore Throat
- Low Blood Oxygen
- Headache

**Advanced Care Planning:**
- HEALTH CARE DIRECTIVE OR LIVING WILL – Location: On file at Essentia and Mayo Clinic
- DO NOT RESUSCITATE ORDER/DO NOT INTUBATE (DNR/DNI) – Location:
- POWER OF ATTORNEY FOR FINANCES – Location:
- PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST, or POST) - Location:
- PSYCHIATRIC ADVANCE DIRECTIVE - Location:

**IMPORTANT:** COVID-19 Person-Centered Description on Reverse Side
MY PERSON-CENTERED DESCRIPTION

Please call me by this name

1. What people like, admire, and appreciate about me

2. What is important to me

3. How best to support me

Completed by: ___________________________ Date: _________________

☐ Me  ☐ Someone else (specify name and role): ___________________________
# COVID-19 PASSPORT

## Personal Information

<table>
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<tr>
<th>First Name:</th>
<th>(Nickname):</th>
<th>Last Name:</th>
<th>DOB:</th>
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<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City, State, ZIP:</th>
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<th>Phone number:</th>
<th>Preferred Language:</th>
<th>Emergency Contact Name and Phone/Email:</th>
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<th>Legal Representative Name and Phone/E-mail:</th>
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<th>Insurance Information:</th>
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<tr>
<th>Primary Care Provider/Contact Information:</th>
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## Medications / Risk Factors

**MEDICATIONS:**

- Long-term care resident
- Transplant:
- COPD/Emphysema/Asthma
- Current/former smoker
- Liver disease
- Intellectual disability
- Neurological disorder
- Heart disease
- Corticosteroid use
- Mental illness/substance use

**COVID-19 Severity Risk Factors (check all that apply):**

- Cancer
- Age 65 or older
- Pregnant
- Severe obesity (40+ BMI)
- HIV/AIDS
- Kidney disease
- Homeless
- Other:

*Note: Information on this form may not be complete*

## Assistive Devices/ Health Conditions

<table>
<thead>
<tr>
<th>Allergies and Diet Restrictions</th>
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</table>

## Current COVID-19 Symptoms

- Temp. over 100.4°F
- Dry cough
- Malaise/Fatigue
- Shortness of Breath
- Nasal Congestion
- Diarrhea
- Loss of Smell/Taste
- Sore Throat
- Low Blood Oxygen
- Headache

### Advanced Care Planning (check all that apply and and location of document if known)

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- PSYCHIATRIC ADVANCE DIRECTIVE - Location:

### IMPORTANT: COVID-19 Person-Centered Description on Reverse Side
Person-Centered Description and Healthcare Passport

Acknowledgments

Concepts, principles, materials, and tools from:

*The Learning Community for Person Centered Practices*
https://tlcpcp.com/

*Support Development Associates*
https://www.sdaus.com/

*National Center on Advancing Person-Centered Practices and Systems*
has additional resources and a fillable version of their Person-Centered Profile tool and examples used by people with a range of different backgrounds and experiences.

https://ncapps.acl.gov/covid-19-resources.html

This resource is provided by:

The Office of Kansas Long-Term Care Ombudsman working to enhance the quality of life and the quality of care and services for residents of long-term care through advocacy, education, and empowerment. All services are free and confidential.

Contact The Office of the Kansas Long-Term Care Ombudsman:
Phone: 785-296-3017, (Toll Free) 1-877-662-8362
Email: LTCO@ks.gov or visit: ombudsman.ks.gov.

Thank you to the Minnesota LTCO Program for the use of their format to recreate this resource.
Additional Resources

- KS COVID-19 UPDATES: You can stay up to date on COVID-19 on Kansas Department of Health & Environment’s (KDHE) website: [https://www.coronavirus.kdheks.gov/](https://www.coronavirus.kdheks.gov/)

- KANSAS COVID-19 PHONELINE: For questions related to the COVID-19 pandemic, call 866-534-3462; Mon-Fri: 8:30 AM-5 PM.

- CMS Nursing Home Resource Center

- Kansas Adult Protective Services (Kansas Adult Abuse Reporting Center): 1-800-922-5330

- Kansas Department of Aging & Disability Services Long-Term Care Facility Complaints: 1-800-842-0078.