# EMERGENCY INFORMATION About Me - Patient Profile

You can add a photo here

This Patient Profile is recommended for you to print out and keep somewhere that is easy to access in the event of an emergency. For example, you would share this with ambulance staff, so they understand your communication and support needs.

**It is recommended that this Patient Profile is reviewed yearly to make any changes or updated as changes occur.**

**My patient information**

My name:

Please tick – My pronouns: [ ]  She / her [ ]  He / him [ ]  They / them [ ]  Other

Date of birth (dd/mm/yyyy):

Address:

Phone number:

Please tick – My main language spoken at home is:

Do you need another person to assist you to communicate? [ ]  Yes [ ]  No

[ ]  Key worker [ ]  House supervisor [ ]  Interpreter [ ]  other (e.g. parent, sibling)

Please tick – I identify as Aboriginal and or Torres Strait Islander: [ ]  Yes [ ]  No

Please share – My cultural and spiritual needs are:

Please share – My primary disability is:

Please share – My other disabilities are (if required):

Other information you may wish to share:

Please share – My key health information is:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Document** | **Number** | **Name** | **Expiry date** | Optional: add image of card |
| Medicare Card |  |  |  |  |
| Health Care Card |  |  |  |  |
| Veterans Card |  |  |  |  |
| NDIS Plan |  |  |  |  |
| Other |  |  |  |  |

**My consent**

I, (patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provide my consent for this About Me – Patient Profile to be kept on file at (name of clinic):

***Note:*** *You may have a key person or supporter in your life who knows you best. This may be a key worker, house supervisor or other (parent, sibling etc). Please provide their name and details so we can talk directly to them, and they can give us information on your behalf.*

Name (supporter name):

Their relationship to me is:

Their phone number:

This form was completed on (date) (dd/mm/yyyy):

Name (supporter name):

Their relationship to me is:

Their phone number:

This form was completed on (date) (dd/mm/yyyy):

**Decision-making**

***Note:*** A ‘medical treatment decision maker’ is someone who has legal authority to make medical treatment decisions for you under the Victoria’s *Medical Treatment Planning and Decisions Act 2016*.

Please tick – I have a legal Medical Treatment and Decision Maker: [ ]  Yes [ ]  No
If yes, their name is:
Their relationship to me is:
Their phone number is:

**How I communicate**

**For example**, I use a communication device. I can take 30 seconds to think and answer questions.

Please share – The way I communicate is:

**Optional:** Record a short video and add the link here:

 Weblink for video:

**How you should communicate to me**

Please tick and share – I need health professionals to communicate with me by:

[ ]  Talk slowly and use easy words.

[ ]  Ask me before touching me.

[ ]  Give me time to think and answer questions.

More information:

**3 things to connect with me**

For example, I have a dog named Larry. I like gardening. Please ask about my day.

1.
2.
3.

**3 things I do not like when I see a health professional**

For example, I don’t like needles. I don’t like being touched without knowing what people are doing.

1.
2.
3.

**My treating health professionals**

My GP clinic:

My doctor or GP:

Clinic phone number:

**Note:** This section below is for listing health professionals only. Health professionals may be the doctor or GP, practice nurse, specialists, paediatrician, neurologist, diabetes nurse, allied health professionals, occupational therapist, speech pathologist, mental health professionals, audiologist (hearing), optometrist (vision).

|  |  |  |  |
| --- | --- | --- | --- |
| Health professional type(Eg. Psychologist) | Name of health professional (Eg. John Smith) | Name of organisation or clinic | Phone number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**My allergies**

|  |  |
| --- | --- |
| Things I am allergic to: | My allergic reaction: |
|  |  |
|  |  |

**My medications**

Date this was form was completed (dd/mm/yyyy):

|  |  |  |
| --- | --- | --- |
| Name of medication  | Dose (how much)  | Frequency (how often) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Other key information (such as if any of these are new medications):

**Past medical history**

Please tick – Important parts of my health and medical history are:

|  |  |
| --- | --- |
| [ ]  Arthritis | [ ]  Constipation  |
| [ ]  Asthma | [ ]  Dental disease |
| [ ]  Back pain | [ ]  Disability |
| [ ]  Cancer | [ ]  Dysphagia / swallowing difficulties |
| [ ]  Cardiovascular disease / heart problems | [ ]  Epilepsy / seizures |
| [ ]  Chronic obstructive pulmonary disease (COPD) / lung problems  | [ ]  Gastrointestinal problems  |
| [ ]  Chronic kidney disease | [ ]  Hearing impairment |
| [ ]  Diabetes | [ ]  Malnutrition |
| [ ]  Mental health conditions (such as depression, anxiety, PTSD) | [ ]  Obesity  |
| [ ]  Osteoporosis | [ ]  Reflux |
| [ ]  Trauma | [ ]  Sleep disorder |
| [ ]  Abuse | [ ]  Vision impairment |

More information:

**My Health Record**

Please tick – I would like my health information added to My Health Record:
 [ ]  Yes [ ]  No

**Consent to share this information**

Please tick – I consent for this “EMERGENCY INFORMATION About Me - Patient Profile” to be shared with ambulance staff, hospital staff and relevant others:
 [ ]  Yes [ ]  No
Who provided this consent:

Date (dd/mm/yyyy):