All About Me

My Details

Full name

Preferred name

Date of Birth

Address

Phone

Medicare Number

Disability Pension or Health Care Card details

Private Health details

Insert Photo of You

Communication Method

- ☐ See attached Communication Profile; OR
- ☐ Detail how you communicate and what level of support or strategies you need.

Consent

- ☐ I provide all consent
- ☐ I provide all medical history and information required
- ☐ I have an Enduring Power of Attorney / Guardianship Order (attach copy)
- ☐ I have an Advanced Health Directive (attach copy)
- ☐ I have an Advocate assist me; OR
- ☐ Detail who has legal decision making authority, including after hours contact.
  Detail who to contact for medical history and other health information.

My Contacts

Next of Kin

Name	
Relationship	
Contact details	
Level of Support	☐ Emergency contact only ☐ Involved in decision making

Family/Carer

Name	
Relationship	
Contact details	
Level of Support	Describe your desired level of involvement and support of your family and carers

GP Details

Name	
Contact details	
Specialists	Name, Hospital or rooms, contact details

Disability Support Organisation Details

Name of organisation	
Type of support e.g. accommodation, professional services.	Describe what type of support is provided e.g. 24 hour support, personal care, intermittent nursing, Registered Nurses 24 hour
	Detail what type of service you receive.
Contact details including after hours and key personnel	

Disability Therapy Provider Details

Name of organisation	
Type of support e.g. accommodation, professional services.	Detail what programs or support are provided by therapists, phycologists, social workers, dietitians and other allied health professionals.
	Detail what type of service you receive.
Contact details including after hours and key personnel	List your therapists, social worker, psychologist, dietitian and other health professionals

My Health

Allergies	Detail any allergies you have or write Nil Known if you do not have any allergies.
Alerts	Detail anything that is very important for health professionals to know about you.
Diagnosis	
Secondary conditions	
Other health conditions	
Specific health needs or "Your Normal"	Describe any specific signs and symptoms for you or anything specific about your condition that is relevant to you. Describe Your Normal.

My Health

Current medications	☐ See attached medication chart OR Detail all medications, dosage, reason and who prescribed the medication as well as your local pharmacy.
Past Medical / Surgical History	List your past medical and surgical history, illnesses and hospital admissions.
Immunisation Record	
Mealtimes	☐ See attached mealtime plan OR Detail whether you have any modifications to your food or fluids.
Support Needs	Detail what support you need for personal care. E.g. full support, supervision or support for some tasks. Include: Eating and drinking, Showering, Toileting, Dressing, Behaviour

My Health

Mobility needs	Detail how you move, how you transfer, what equipment you use, any falls risk
Equipment and assistive technology	Detail what equipment and assistive technology you use
Other aids	Detail any other aids you have e.g. glasses, hearing aids
Transport needs	Detail what transport methods you use e.g. private vehicle, disability accessible vehicle, taxis, buses
Dietary needs	☐ See attached diet/nutrition plan OR Detail any dietary needs you have

Anything else you what to share