HEALTH PASSPORT

CONSUMER INFORMATION

First Name:		Last Name:			
Address:		City, State, Zip:			
Home Phone:		Agency Phone:			
Birth Date:	Age:	Sex:	Race:	Height:	Weight:
Social Security #:		Hair Color:	Eyes:		
Medicaid #:	DNR / DNI? (If yes, please attach) Yes ☐ No ☐				
Medicare #:					
Medical Insurance Provider and Number:					

CONTACT INFORMATION

Guardian:	Guardian Home Phone:
Guardian Address:	Guardian Work Phone:
Next of Kin (relationship):	Next of Kin Home Phone:
Next of Kin Address:	Next of Kin Work Phone:
Provider Agency:	Provider Office Phone:
Agency QMRP:	QMRP Phone :
Agency RN:	RN Phone :
DDA Service Coordinator:	DDA Service Coordinator Phone #:
Primary Physician:	Physician phone #:
Physician address:	
Primary Dentist:	Dentist phone #:
Dentist address:	
Primary Psychologist:	Psychologist phone #:
Psychologist address:	
OB/GYN:	OB/GYN phone #:
OB/GYN address:	
Specialist:	Specialist phone #:
Specialist address:	
Specialist:	Specialist phone #:
Specialist address:	

FUNCTIONAL INFORMATION

Cognitive Skill Level:	Adaptive Skill Level:
Communication Level:	Communication Method:
Type of Adaptive Equipment:	
Diet:	Food Texture:
Food Intolerances:	
Ambulatory: Fully ☐ With Assistance ☐ Non-ambulatory ☐	

CONSENT PROCEDURES

Individual has the capacity to make medical decisions: Yes ☐ No ☐	Individual has a substitute health care decision maker: Yes ☐ No ☐
To obtain consent contact: Name:	Phone:
In a medical emergency two physicians may agree to proceed with medical intervention.	

MEDICAL INFORMATION

ALLERGIES:
SPECIAL PRECAUTIONS:

DSM-IV AXIS	***CURRENT DIAGNOSES***
I	
II	
III	

Vaccine Administration Record for Adults

Patient Name:

Birth Date:

Chart Number:

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Update the patient's personal record card or provide a new one whenever you administer vaccine.

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine		Vaccine Information Statement		Signature/ initials of vaccinator
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, (Pertussis) (e.g.,Td,Tdap) Give IM.									
Hepatitis A[3] (e.g.HepA, HepA-HepB) Give IM.									
Hepatitis B[3] (e.g.HepB, HepA-HepB) Give IM.									
Human Papillomavirus (HPV) Give IM.									
Measles, Mumps, Rubella (MMR) Give SC.									
Varicella (Var) Give SC.									
Pneumococcal, polysaccharide (PPV) Give SC or IM.									
Meningococcal (e.g., MCV4, conjugate; MPSV4, polysaccharide) Give MCV4 IM. Give MPSV4 SC.									
Zoster (Zos) Give SC.									
Influenza (e.g., TIV, inactivated; LAIV,live, atternated) Give TIV IM. Give LAIV IN.									
Other									
Other									

1. Record the generic abbreviation for the type of vaccine given (e.g., PPV, HepA-HepB), not the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds.
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each separate antigen in the combination.

Technical content reviewed by the Centers for Disease Control and Prevention, Sept. 2006.

www.immunize.org/catg.d/p2023b.pdf • Item #P2023 (9/06)

Distributed by the Immunization Action Coalition • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

CURRENT MEDICATIONS

Date Started	MEDICATION	DOSAGE	FREQUENCY	TIMES	ROUTE	REASON

DISCONTINUED MEDICATIONS

Date Started	Date Discontinued	MEDICATION	DOSAGE	FREQUENCY	TIMES	ROUTE	REASON

Medical Problem

Medical Problem	Date Diagnosed	Date Resolved	Initial

* Initial each dated entry

Initial Log

Printed Name: _____
Signature: _____ Initial: _____ Date: _____

Printed Name: _____
Signature: _____ Initial: _____ Date: _____

Printed Name: _____
Signature: _____ Initial: _____ Date: _____

Printed Name: _____
Signature: _____ Initial: _____ Date: _____