Name:

COVID DISABILITY HOSPITAL KIT

Important information for people supporting or treating me in a COVID-19 emergency

www.nobodyleftbehind.com.au

Please make sure I take this with me if I need to go to hospital or to visit a doctor if I contract COVID-19

Health and Support Information

Important information for people supporting/treating me

If you are involved with my care and support, please read this information.

This is not a medical record.

This document gives important information about:

Section A: Essential information – personal and medical information you MUST know

Section B: My disability support needs

Section C: Things that are important to me

Please carefully read the information, including the sections about **communication** and **decision-making**.

Please return this document to me when I leave.

Section A: Essential Medical Information

My name is: _____

I like to be known as: _____

My pronouns are: _____

My gender identity is: _____

My date of birth is: _____

My address is: _____

I live with: _____

My mobile phone number is: _____

My email address is: _____

Section A: Essential Medical Information

My cultural background and/or spiritual beliefs are:

_____

My Medicare number is: _____

My next of kin is: _____

My key support people are:

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

My doctor or general practitioner (GP) is:

Name: _____

Practice:_____

Contact details: _____

My Medical Information

This is what I want to tell you about my disability and/or health condition/s.

(You may wish to write here about your impairment and/or other health condition/s. For example: I have cerebral palsy and use a wheelchair for mobility; I have epilepsy and my seizures vary from mild seizures to strong seizures that may last up to 3 minutes; I am autistic and have issues with noisy/bright environments; etc.)

Section A: Essential Medical Information

I usually take this medication:

(include dose & how it is taken i.e. tablet, liquid)

Medication:	Dose:	Frequency:	Form: (i.e. tablet, liquid)

When giving me medication, please: (e.g., crush my tablets)

_____

If you need to do a medical assessment with me, please: (lay me on my left side, be aware that I have a leg bag/catheter, etc)

_____

_____

_____

Section A: Essential Medical Information

Medical history and treatment plan: (major surgeries, medical interventions and current care plans)

I am allergic to: (e.g., medicines, perfume, nuts, etc)

Pain

☐ I can tell you when I am in pain.

☐ I can't tell you when I am in pain.

☐ I can use a regular pain scale.

☐ I need a different type of pain scale (visual, COMFORT or comparable).

These are ways that I might show you that I am in pain if I do not use spoken language.

Safety

Check the box next to the statement that applies to you.

☐ No, I don’t need support with my safety.

Please go to section B.

☐ Yes, I may need support in keeping safe.

Please read information below.

Things important for my physical safety: (e.g., raised bed rails, sharp objects removed from room, I require observation as I may leave the room unexpectedly without advising others, etc)

Section B: My Disability Support Needs

Things that upset me or cause me stress are: (e.g., bright lights, loud noise, etc)

You would know that I am anxious or stressed when: (e.g., I start rocking my body, I start biting myself, I start banging my hands, etc)

Section B: My Disability Support Needs

Things you could do to help me settle down are: (e.g., play soft music, take me out for a walk, help me access my iPad, call the crisis team, etc)

Other things you might need to know about me, including any other conditions such as psychiatric conditions or other support needs (ie trauma history, gender preference with care, ways to support my mental health)

My Communication

My first (or preferred) language is: _____

I need help with interpreting

☐ Yes

☐ No

I communicate with people by using:

☐ Spoken English

☐ other spoken language

☐ Auslan

☐ Australian Key Sign English

☐ Communication device

☐ Alternative and Augmented Communication (AAC)

☐ Other (gestures, facial expressions, picture charts, hearing aid, digital diary, PODD etc)

☐ I identify as Deaf and/or hard of hearing

Section B: My Disability Support Needs

Things you need to know when communicating with me are: (e.g., speak slowly and clearly, face me, tap my shoulder for attention, turn on my equipment, etc)

Please care for my communication equipment by:

(e.g., charge every night, return to protective cover when I am not using it)

My Decision Making

I can and would like to make my own decisions, so please ask me first.

I may need this support to make health decisions and to have treatment:

☐ Supported decision making (help from someone I know and trust to help me make important health decisions)

☐ Independent advocacy

☐ Communication support or interpreting

☐ Easy English, PODD or other information formats

a) Do I have a legal representative for the purposes of medical decision making?

☐ Yes

☐ No

My legal representative is: _____

Legal relationship: (e.g., guardian, public guardian or trustee, etc) _____Contact:_____

b) Do I have advance directives? (see item (c) below)

☐ Yes ☐ No

My advance directives can be found at: (e.g., on my medical file, in cupboard at home, I have given directives to my child, etc)

c) (Please note that this section applies only if I have ticked 'No' to both sections a and b above.)

☐ I do not have a legal representative or advance directives and trust that any decision concerning my care and welfare will be made by myself with full support provided to uphold my decision making, with appropriate professional/s.

☐ I trust that medical professionals will act in my best interests after taking into account my views if they are known, consulting people who know me and care about me and on the basis that I have the same rights as any other patient.

You can find out more about supporting my health decisions at the end of this resource.

My Daily Support

I need assistance with the following:

- ☐ Eating
- ☐ Drinking
- ☐ Using the toilet
- ☐ Showering
- ☐ Transferring
- ☐ Dressing
- ☐ Coughing (I use a cough assist machine)
- ☐ Breathing

  (I use BPAP or other mechanical ventilation)
- ☐ Mobility

  (I use a power or manual wheelchair or other mobility aid)
- ☐ Taking medication
- ☐ Filling in forms or writing, including menus and consent forms
- ☐ Help to understand difficult health information

Section B: My Disability Support Needs

- ☐ Help to support my decisions
- ☐ Transport
- ☐ I need help to stay in bed or to stay calm if I am distressed
- ☐ Modified call bell or other assistance to call for help if required

Other: _____

To hear and see I need:

(e.g hearing aid, glasses, contact lenses, etc.)

Moving Around

Check the box next to the statement that applies to you.

☐ No, I don’t need support with moving around.
Please go to Daily Activities.

☐ Yes, I may need support with moving around.
Please read information below.

I move around using: (e.g., I can walk with the support of a wall, I can see only up to a certain distance, I use a hoist for transfers, I have a guide dog, etc)

Section B: My Disability Support Needs

Things you need to know when supporting me to move around: (e.g., roll me on one side when helping me to move in bed, let me hold your left arm when you are guiding me, please put my power wheelchair on charge at night, etc)

Please care for my equipment by: (e.g., put on charge when not in use, making sure my wheelchair is at my bedside, if stored ensure it is stored according to my instructions)

Daily Activities

Check the box next to the statement that applies to you.

☐ No, I don’t need support with daily activities.

Please go to Section C.

☐ Yes, I may need support with daily activities.

Please read information below.

My mobility and falls risk

e.g. walk with assistance, need to be wheeled in wheelchair

Section B: My Disability Support Needs

How I use the toilet

e.g. continence aides, help to get to the toilet

Personal care e.g. dressing and washing

How I eat e.g. food cut up, pureed, help with eating

Section B: My Disability Support Needs

How I drink e.g. small amounts, straw

Seeing/hearing e.g. problems with sight or hearing

How to keep me safe

e.g. bed rails, support with challenging behaviour

Section B: My Disability Support Needs

My comfort items

e.g. things that reduce my anxiety

Sleeping

e.g. my sleeping pattern/routine

My Preferences

Things I like: (e.g., music, routines, etc)

Things I don’t like: (e.g., certain food, dark rooms, etc)

My dietary preferences:

Section C: Things That Are Important To Me

My cultural needs: (e.g., I prefer a woman doctor, require a ward with men only, etc)

Other information: (e.g., tell me when you bring food and what's in it, etc)

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Resources

https://adacas.org.au/information-resources/supported-decision-making/

https://www.health.gov.au/sites/default/files/documents/2021/06/covid-19-vaccination-information-for-disability-service-providers-on-consent.pdf