Autism Health Passport

This document is about communicating your needs as an autistic person, when accessing health and mental health services. There are three sections in the Health Passport:

- **My Health Passport:** A section about your general health, communication and sensory needs. This can be used for places like GP surgeries and pharmacies
- **My Hospital Passport:** This section is about what support you would like when you are going to hospital, as a visitor or as a patient
- **My Mental Health Passport:** This is a section you can use for when you are accessing mental health services, including therapies and counselling funded by your GP

Professionals: How to use this document.

This document is to help autistic patients when accessing health and mental health services. It covers communication needs, sensory needs, their health conditions and more.

To record what the person who this profile belongs to has said, use the data in this section only and input it into your database. Then, when the patient is in an appointment with you, please ensure that their needs as an autistic person are met. They include sensory, communication and how they experience pain.

Autistic people: How to use this document

This passport can help you when accessing health and mental health services. It can help you to talk about your communication, medical and sensory needs if unable to do it verbally or face-to-face. Most of the questions on here ask you to click on a box. Please click on boxes next to questions if they apply to you.

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1. My Health Passport

About Me

My name is:
I like to be called:
My pronouns are:
My date of birth (birthday) is:

This book tells you about me and the reasonable adjustments I need at the doctors or in hospital. This book belongs to me. Please read it and give it back to me.	
You **can** keep a copy in my medical notes	☐
You **cannot** keep a copy in my medical notes	☐
I will check this book each year and change it if I need to. Please make sure you have the most recent version.	

Emergency Contact:			
Telephone		**Email**	
Relation to me			
Family	☐	**Support staff**	☐
Friends	☐	**Other professionals**	☐
Partner	☐	**Other**	☐
Emergency Contact:			
Telephone		**Email**	
Relation to me			
Family	☐	**Support staff**	☐
Friends	☐	**Other professionals**	☐
Partner	☐	**Other**	☐

Please let us know if you have any additional diagnoses or conditions that you would like to disclose?		
Physical Condition	Mental Health Condition	Neurodevelopmental Condition
E.g. Diabetes	E.g. Depression	E.g. ADHD

Communication

Please tick the boxes that apply to you.

I wear glasses / contact lenses	☐	**I use a communication aid**	☐
I have a hearing aid	☐	**I sign using Makaton**	☐
My first language is:			
My question and communication preferences:			
I like closed question with yes or no answers.	☐	**I may need help with conversation balancing as I may go off on tangents.**	☐
I like and/or questions, that give me examples or options to pick from.	☐	**I prefer written, drawn, or storyboarded communication (verbal is not preferred).**	☐
I like experience led questions where I am given additional time to speak and express myself.	☐	**I appreciate repetition or pauses for clarity as I may have sensory, information processing delay.**	☐
I may become non-verbal and require a communication aid.	☐	**I may become non-verbal and require a communication aid.**	☐

Examples of changes to my communication when unwell, in pain or distressed:	
Communication Changes:	**Relevant communication adjustments:**

My experience of pain (how pain may look like or feel for me)			
I sometimes mask pain or discomfort.	☐	I am sometimes unaware of my own pain.	☐

Support at health appointments or in hospital

Please tick the boxes that apply to you.

Service Barriers Experienced			Suggested Adjustments and Support
☐	**Inaccessible booking system or format e.g. over the phone**	➡	**Alternative booking arrangements e.g. email booking or proxy booking**
☐	**Unsuitable sensory environment e.g. harsh light**	➡	**Provide sensory tools, adjustments or change the environment e.g. close blinds**
☐	**Unclear prescription instructions or untailored for autistic needs**	➡	**Give detailed instructions wherever possible and ensure context is given to your patient**
☐	**Bad news given in an inaccessible or untailored manner**	➡	**Check the patient's communication profile and create a suitable environment for the patient to process difficult information**
☐	**Appointments too short to express needs or health issues clearly**	➡	**Give the patient a double appointment slot for the extra time required to explain needs**
☐	**Pain, fatigue, or emotion scales lack context or content needed for my use**	➡	**Autism specific pain, fatigue and emotional scales should be made available to your client e.g. Spoon Theory or body mapping**
☐	**Lack of communication support and written summaries**	➡	**Follow the patient's communication preferences and give detailed appointment summaries**
☐	**Phobia of needles and sharp medical tools.**	➡	**Discuss options to distract or avoid needles/ sharp medical tools e.g. music or blind fold.**

Other reasonable adjustments that I need:
Please use this box to list relevant options for your reasonable adjustments. Example: I have difficulty being observed when eating and I would prefer a quiet, unpopulated room to have my meals on an inpatient ward.

My Sensory Needs

Please say how you process light, sounds, smells, tastes, internal processes, balance, and texture. Please explain whether you are hyper or hyposensitive to certain senses.
Example: If you are really sensitive to light, then you may seek to reduce certain light exposure e.g. dimming lights. If you are not very sensitive to sound, then you may seek loud noises or music.

My experience of Sounds:	☐
My experience of Smells:	☐
My experience of Light / Lighting:	☐
My experience of Taste:	☐
My experience of Internal Senses (Hunger, Thirst, Balance and Bladder Control):	☐
My experience of Touch:	☐

I do not like to be touched (Please ask if necessary)	☐	**I often 'stim' to help my anxiety**	☐
I need to sit away from the door to avoid noise and movement	☐	**I need to sit near the door, or I may feel anxious / agitated / trapped**	☐
I often verbally 'stim' to help my anxiety	☐	**I need frequent movement breaks to maintain focus**	☐

Are there any other sensory needs or difficulties you would like us to be aware of?
E.g. sensory processing needs

My likes, dislikes, and interests

Please tell us about what you like the most, what you dislike and your interests.

My likes include:
My dislikes include:
My main interests are:

Making decisions (Capacity)

Please think about the processes or environment you need to make informed decisions. Example: A quiet space to go over written storyboards of each option and outcome.

To help me make decisions, I will need:		
Sensory environment Example: Weighted blanket.	**Question and communication patterns** Example: Closed questions.	**Information Processing Needs** Example: Voice to text software.

If I need help to make decisions, please contact:	
If any decisions need to be made in my best interest, please contact:	
I have lasting power of attorney	Yes ☐ No ☐
Details on your power of attorney (if applicable):	
I have advance directive	Yes ☐ No ☐
Details on your advance directive (if applicable):	

My mobility and movement

Please tell us about your mobility needs and what aids you in your movement.

Do you have any difficulties with moving around e.g. walking, running or climbing stairs?			
Yes	☐	**No**	☐
If you need aids to help you move, what do you use? E.g. walking frame, wheelchair, walking stick			
Can you travel independently by driving a car, bicycle, walking and/or by using public transport?			
Yes	☐	**No**	☐

Specialist equipment I need

Please tell us about any specialist equipment you need to help you manage day to day.

If you have any specialist equipment or require equipment, then please list these below:

2. My Hospital Passport

Support at the Hospital

Please tell us about what support you might need when you are in a hospital ward.

I often need help with the following things:

Eating, Drinking and Taking Medications

Please say how you eat, drink, and take any medication

I eat and drink:			
Independently	☐	**With support**	☐
I do have problems swallowing	☐	**I like to eat alone or in a quiet room.**	☐
I can eat and drink: Example: I prefer soft, less textured foods, such as mashed potato.			

Preferences when eating and taking medications:	
Sensory Environment: Example: I like to take my medication with privacy curtains closed and headphones on.	**Routine or Rituals:** Example: I like to take my medication with a spoonful of jam.

My sleep pattern and routine

Please tell us about when and how long you go to sleep for and what you usually do on a typical day.

Disclaimer: Ward staff may not be able to adjust their schedule to your sleep pattern or routine, but this is still useful information for the ward staff.

<table>
<tr><td colspan="3">I usually go to sleep at:</td><td colspan="2"></td></tr>
<tr><td colspan="3">I usually wake up at:</td><td colspan="2"></td></tr>
<tr><td>I need to sleep:</td><td>By the door</td><td>☐</td><td>Away from the door</td><td>☐</td></tr>
<tr><td colspan="3">I usually sleep for:</td><td></td><td>hours per day</td></tr>
<tr><td colspan="5">Every day, I usually do these routines:
Example: visits, hobbies, chores, or religious activity</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5">Every week, I usually do these routines:
Example: Weekend run or going to work.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

3. My Mental Health Passport

My mental health history

Do you experience or have a diagnosis of any of the following? Autism is not a mental illness. Autistic people can experience mental health issues in the same way as a neurotypical person.

Please tick any that apply to you:			
Alcohol or Drug Use Disorder	☐	**Auditory hallucinations**	☐
Anxiety (Including Generalised Anxiety Disorder (GAD), Panic or Anxiety Attacks)	☐	**Depression**	☐
Bipolar Disorder	☐	**Hoarding**	☐
Eating Disorder (ED)	☐	**Obsessive-Compulsive Disorder**	☐
Isolation	☐	**Personality Disorder**	☐
Panic Attacks	☐	**Psychosis**	☐
Post-Traumatic Stress Disorder (PTSD)	☐	**Self-Harm**	☐
Schizoaffective Disorder or Schizophrenia	☐	**Self-Neglect**	☐
Self-Medication	☐	**Suicidal Thoughts or feelings**	☐

Do you have any other conditions or diagnoses that you would like us to be aware of?

Previous treatments and strategies

Unlike neurotypical people, if an approach has not worked for an Autistic person in the past, it is unlikely to work if attempted again later. Thinking about your Mental Health: What has and has not helped in the past? (Please tick those boxes that apply)

Name of treatment	Has worked	Has not worked
Person-Centred Talking Therapy	☐	☐
Solution-Focused Therapy (E.g. Cognitive Behavioural Therapy (CBT))	☐	☐
Group Therapy	☐	☐
Help to work out practical strategies	☐	☐
Help to understand emotions	☐	☐
Help to manage and regulate emotions	☐	☐
Help to understand your Mental Health challenges	☐	☐
Understanding triggers that lead to crisis	☐	☐
Strategies to manage crisis	☐	☐
Medication	☐	☐

Are there any other treatments/strategies that have worked in the past that you would like us to know about?

Are there any other treatments/strategies that have not worked in the past that you would like us to know about?

Ways to help me avoid distress

In this section, please tell us about what can help you to avoid distress when accessing health and mental health services. Tick any boxes that apply to you.

Name of method			
Ask me about my hobbies / 'special interests'	☐	I use fidget toys to help manage my anxiety	☐
I am calmed by certain textures	☐	I am calmed by repeating certain movements	☐
I am calmed by repeating certain phrases / sounds	☐	Do not expect me to look directly at you	☐
Instruct me as to where I should sit	☐	Be clear when our appointment has ended and what is going to happen next	☐
Are there any other ways to help you avoid distress? If so, please write them down in the box below:			
Professionals involved in care:			