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| Note: **This template must be completed in conjunction with the Coordinated Care Plan user guide.** |

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| My Identifiers  |
| Given name**:**  | Preferred name**:**  | Surname**:**  |
| Date of birth**: YYYY-MMM-DD** | Gender**:**  | Preferred pronoun**:**  |
| Address**:**  |
| City**:** | Province**:**  | Postal code**:**  |
| Telephone number**:**  | Alternate telephone number**:**  |
| Health card number**:**  | Issued by:  | Ancestry/culture**:**  |  |
| Identify as First Nation, Métis, or Inuit? | If “yes,” specify which nation**:**  |
| Language of comfort**:**  | Communication accommodations**:**  |

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| **What’s Most Important To Me and My Concerns** |
| What is most important to me right now**:**  |
| What concerns me most about my health care right now**:**  |

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| My Care Team (Include active family/caregivers, providers) |
| Coordinating lead (notify if patient is hospitalized) | Name**:**  | Phone number**:**  |
| Name of team member | Role | Organization | Contact information | Share coordinated care plan |
| Primary number | Secondary number |
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| Health Care Consent and Advance Care Planning |
| **Note: Ensure that you’ve obtained all necessary consents to treatment from the patient or the SDM as required by law.** |
| My health substitute decision maker(s) (SDM) is/are |
| Name | Relationship | Type of SDM | Contact information |
| Primary phone number | Secondary phone number |
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| I have shared my wishes, values, and beliefs with my future SDM as they relate to my future health care**:**   |

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| My Health(Include physical health, mental health and addictions [i.e. smoking], functional issues, assistive devices) |
| Issues | Details (onset, considerations) |
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| More About Me  |
| Topics | Details |
| Income |  |
| Employment  |  |
| Housing |  |
| Transportation |  |
| Food security |  |
| Social network |  |
| Health knowledge |  |
| Newcomer to Canada |  |
| Legal  |  |
| Spiritual affiliation |  |
| Caregiver Issues |  |
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| My Goals and Action Plan |
| What I hope to achieve | What we can do to achieve it | Details | Who will be responsible | Date goal identified(YYYY-MMM-DD) |
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| My Medication Coordination (Attach current medication list or complete the medication appendix) |
| Most reliable source for medication list (primary prescriber/medication manager/family)**:**  |
| Aids I use to take my medications**:**  | If someone helps you with medications, who helps you? |
| Challenges I have taking my medications (side effects, are you able to afford all your medications?)**:**  |

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| My Allergies | No known allergies **☐** |
| What are you allergic or intolerant to? | What happens to you? What are your symptoms? |
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| **Appendices attached:** | [ ]  **Medication List** | [ ]  **My Health Assessments** | [ ]  **Most Recent Hospital Visit** | [ ]  **Palliative Approach to Care** |

**Appendix 1**

**It is recommended to obtain the most recent medication reconciliation from provider/source where it was most recently completed (e.g. pharmacy, hospital, primary care)**

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| **My Medication List** |
| Drugs/medicine | Dose | How often am I taking this medication? | Why am I taking this medication? | Who prescribed the medication? | When did I start taking this medication? | Notes |
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**Appendix 2**

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| **My Health Assessments** |
| Assessment type and name | Date completed | Notes |
|  | **YYYY-MMM-DD** |  |
|  | **YYYY-MMM-DD** |  |
|  | **YYYY-MMM-DD** |  |
|  | **YYYY-MMM-DD** |  |

**Appendix 3**

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| **My Most Recent Hospital Visit** |
| Hospital name: | Visit date: **YYYY-MMM-DD** |
| Reason for visit: |
| Visit description:  | **☐** Emergency room to home | **☐** Emergency room to inpatient unit |
| Date of discharge**: YYYY-MMM-DD** | Length of stay**:**  |
| Comments**:**  |

Appendix 4

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| **Palliative Approach to Care** |
| The person most responsible for my palliative care is**:**  |
| Physical support plan (pain management, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, drowsiness)  |
| Symptoms | Treatments | Comments |
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| Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem) |
| Symptoms | Treatments | Comments |
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| Social support plan (relationships, family caregiver, volunteers, environment, financial, legal)**:**  |
| Spiritual support plan (values, beliefs, practices, rituals)**:**  |
| Preferred place of death**:**  |
| Grief and bereavement support**:**  |
| Other**:**  |