

## \_\_\_\_\_’s Coordinated Care Plan

Last updated by: \_\_\_\_\_

Last updated date (YYYY-MMM-DD): \_\_\_\_\_

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

### 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:			

### 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:

### 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	

### 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

I have shared my wishes, values, and beliefs with my future SDM as they relate to my future health care:

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<b>My Health</b> (Include physical health, mental health and addictions [i.e. smoking], functional issues, assistive devices)	
Issues	Details (onset, considerations)

<b>More About Me</b>	
Topics	Details
Income	
Employment	
Housing	
Transportation	
Food security	
Social network	
Health knowledge	
Newcomer to Canada	
Legal	
Spiritual affiliation	
Caregiver Issues	

<b>My Goals and Action Plan</b>				
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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<b>My Medication Coordination</b> (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?):	

<b>My Allergies</b>		No known allergies <input type="checkbox"/>
What are you allergic or intolerant to?	What happens to you? What are your symptoms?	

<b>Appendices attached:</b> <input type="checkbox"/> Medication List <input type="checkbox"/> My Health Assessments <input type="checkbox"/> Most Recent Hospital Visit <input type="checkbox"/> Palliative Approach to Care
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**Appendix 3**

<b>My Most Recent Hospital Visit</b>	
Hospital name:	Visit date (YYYY-MMM-DD):
Reason for visit:	
Visit description: <input type="checkbox"/> Emergency room to home	<input type="checkbox"/> Emergency room to inpatient unit
Date of discharge (YYYY-MMM-DD):	Length of stay:
Comments:	

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Appendix 4

<b>Palliative Approach to Care</b>		
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
Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem)		
Symptoms	Treatments	Comments
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:		