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| Lead Care Coordinator: | Agency: |
| Date of first submission to NECCAC: 30/11/2016 |
| ***Fax Completed Care Plans to: North East Community Care Access Centre; 705-522-3855*** |

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| **My identifiers** | Last updated: Click here to enter a date. | Last updated by:  |
| Given name: | Preferred name:  | Surname:  |
| Gender: Choose an item. | Date of birth:  | OHIP insured: Choose an item. |
| Address:  | City:  | Health card #:  |
| Province: | Postal code:  | Preferred contact by: Choose an item. |
| Telephone #:  | Alternate telephone #: | Email address:  |
| Mother tongue:  | Preferred official language: Choose an item. | Ethnicity/Ancestry: |
| Marital status: Choose an item. | Where I currently live: Choose an item. |
| People who live with me: Choose an item. | People who depend on me: |
| **Substitute decision maker (SDM)/Power of Attorney (POA):** | **SDM/POA telephone #:**  |
| **Emergency contact:** | **Emergency contact telephone #:**  |

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| **My care team** | Last updated: Click here to enter a date. | Last updated by: |
| Name | Role or relationship | Organization | Telephone # | Regular care team member | Lead care coordinator | I rely on most at home |
|  |  |  |  | Choose an item. | **☐** | **☐** |
|  |  |  |  | Choose an item. | **☐** | **☐** |
|  |  |  |  | Choose an item. | **☐** | **☐** |
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|  |  |  |  | Choose an item. | **☐** | **☐** |
|  |  |  |  | Choose an item. | **☐** | **☐** |
| The people I rely on at home are: Choose an item. |

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| **My plan to achieve my goals for care** | Last updated: Click here to enter a date. | Last updated by: |
| Care team members who contributed to this plan:  |
| What is most important to me right now: |
| What concerns me most about my healthcare right now: |
| What I hope to achieve | What we can do to achieve it | Who will be responsible | Expected outcome | Confidence will achieve | Barriers and challenges | Results so far | Review date |
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| **My plan for future situations** |
| I have a crisis plan: Choose an item. |
| I have received information about advance care planning. Choose an item. |
| I have a completed advance care plan. Choose an item. |
| Future situations | What I will do | What I will *not* do | Who will help | Telephone # | Review date |
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| **My health conditions** | Last updated: Click here to enter a date. | Last updated by: |
|  | Condition description | Condition | Date of onset | Stability | Notes |
| Physical Health  |  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
| Mental Health  |  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
| Other (e.g. social) Factors |  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
| **Allergies and intolerances** |
| Substance | Allergy or intolerance | Symptoms | Severity |
|  | Choose an item. | Choose an item. | Choose an item. |
|  | Choose an item. | Choose an item. | Choose an item. |
|  | Choose an item. | Choose an item. | Choose an item. |
| **My situation and lifestyle** | Last updated: Click here to enter a date. | Last updated by:  |
| How I work: Choose an item. | How adequate my income is for my health: Choose an item. |
| Supplementary benefits I receive: Choose an item. Choose an item. Choose an item. Choose an item. |
| I follow my recommended diet: Choose an item. | How adequate my food is for my health: Choose an item. |
| How I travel: Choose an item.  | How difficult it is to travel: Choose an item. |
| How difficult it is to read and understand information about my health: Choose an item. |
| I smoke tobacco: Choose an item. | # of cigarettes/day:  | # of pack years:  | Quit date:  |
| I drink alcohol: Choose an item. | # of drinks in one sitting: Choose an item. | # of drinks/week:  |
| I have ever used other substances: Choose an item. | Which: Choose an item. | How often: Choose an item. |
| I get 30 minutes of physical activity 3x/week: Choose an item. |
| Other considerations (e.g. sleep habits): | Group memberships (e.g. religious, social, etc): |

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| **My assessed health needs** | Last updated:Click here to enter a date. | Last updated by: |
| Assessment type | Assessment name | Completed | Date completed | Score | Actions taken |
| Frailty |  | Choose an item. |  |  |  |
| Health literacy |  | Choose an item. |  |  |  |
| ADL |  | Choose an item. |  |  |  |
| IADL |  | Choose an item. |  |  |  |
| Pain |  | Choose an item. |  |  |  |
| Hospital re-admission risk |  | Choose an item. |  |  |  |
| Cognition |  | Choose an item. |  |  |  |
| Aggressive behaviour |  | Choose an item. |  |  |  |
| Risk of self-harm |  | Choose an item. |  |  |  |
| Mood |  | Choose an item. |  |  |  |

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| **My most recent hospital visit** | Last updated:Click here to enter a date. | Last updated by: |
| Hospital name: | Type of visit: Choose an item. |
| Date of visit: | Date of discharge (if applicable): |
| Reason for visit: | Complications: |
| Name of hospital physician: | Telephone #: |
| Key advice from hospital physician: |
| Follow-up appointment made with: | Date of follow-up appointment: |

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| **My current supports and services** | Last updated:Click here to enter a date. | Last updated by: |
| Contact name | Organization | Services | Telephone # | Email address | Start date | End date |
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| **My known, current medications** | Last updated:Click here to enter a date. | Last updated by: |
| Date of last medication reconciliation: | Performed by: |
| My last medication change was: | It made me feel: Choose an item. |
| Aides I use to take my medications: Choose an item. | Challenges I have taking medications: |
| Drug name | Strength | Route | Frequency | Reason | Pharmacy | Start date | Change date | Prescriber |
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| **My other treatments** | Last updated:Click here to enter a date. | Last updated by: |
| Surgical devices or changes (e.g. pacemaker, transplant, stent): |
| Health education or counselling (e.g. MedsCheck or group counselling): | Next planned date: |
| Assistive devices (e.g. oxygen cylinder, wheelchair): |
| Self-monitoring routines (e.g. daily home blood pressure readings):  |
| Other treatments (include any alternative substances/traditional medicines): |

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| **My top 5 daily routines** | Last updated:Click here to enter a date. | Last updated by: |
| Time of day | What I will do | Contact for questions | Contact’s telephone # |
| Morning |  |  |  |
| Afternoon |  |  |  |
| Evening |  |  |  |
| Overnight |  |  |  |

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| **My appointments and referrals** | Last updated:Click here to enter a date. | Last updated by: |
| Date | Time | Provider name | Purpose | Notes |
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For more information about this Coordinated Care Plan, please contact the Lead Care Coordinator identified on page 1.

For more information about the Greater Sudbury Health Link, please contact the Manager, Service Collaboration, Canadian Mental Health Association – Sudbury/Manitoulin: slefebvre@cmha-sm.on.ca, 705-675-7252, ext. 211.