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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**:** | | | | | | |
| Preferred language**:** | 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**:** | | |