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| **My identifiers** | Last verified:  | Last verified by: |
| Given name: | Preferred name:  | Surname:  |
| Date of birth: | Health Link: | OHIP insured: Choose an item. |
| Health card #: | Telephone #: | Mother tongue: |
| Official language: Choose an item. | Ethnicity/culture: | Religion or social group: |
| 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: |
| **Primary contact:** | **Relationship to me:** | **Telephone #:**  |
| **Emergency contact:** | **Relationship to me:**  | **Telephone #:**  |

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| **My care team** | Last verified:  | Last verified by: |
| Name | Role or relationship | Telephone # | Lead care coordinator | I rely on most at home |
|  |  |  |[ ] [ ]
|  |  |  |[ ] [ ]
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| The people I rely on at home are feeling: Choose an item. |

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| **My health issues** | Last verified:  | Last verified by: |
|  | Description | Clinical description | 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. |  |
| Social Health |  |  |  | Choose an item. |  |
|  |  |  | Choose an item. |  |
| Frailty assessment score: | Assessment type: | Date of assessment: |
| Allergen or intolerant 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. |

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| **My treatments and medications** | Last verified: | Last verified by: |
| Date of last medication reconciliation: | Performed by: |
| My last medication change was: | It made me feel: Choose an item. |
| Aids I use to take my medications: Choose an item. | Challenges I have taking medications: |
| Drug name | Dose | Route | Direction | Reason | Pharmacy | Start date | Change date | Prescriber |
|  |  | Choose an item. |  |  |  |  |  |  |
|  |  | Choose an item. |  |  |  |  |  |  |
|  |  | Choose an item. |  |  |  |  |  |  |
|  |  | Choose an item. |  |  |  |  |  |  |
|  |  | Choose an item. |  |  |  |  |  |  |
|  |  | Choose an item. |  |  |  |  |  |  |
| Special notes or instructions: |
| Significant surgeries and/or implanted devices (e.g. pacemaker, transplant, stent): |
| Assistive devices (e.g. oxygen cylinder, wheelchair): |  |

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| **My plan to achieve my goals for care** | Last verified:  | Last verified by: |
| 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 | Barriers and challenges |
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| **My plan for future situations** |
| I have received information about advanced care planning: Choose an item. |
| I have a completed advanced care plan: Choose an item. | My ACP is located here: |
| I have a Power of Attorney (POA) for personal care: Choose an item. | My POA document is located here: |
| POA for personal care’s name: | Relationship to me: | Telephone #: |
| As I understand it, my advanced care plan says: |

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| **My situation and lifestyle** | Last verified:  | Last verified by:  |
| How I work: Choose an item. | How adequate my income is for my health: Choose an item. |
| Supplementary benefits I receive (select all that apply): Choose an item. Choose an item. Choose an item. Choose an item.  |
| I smoke tobacco: Choose an item. | I drink alcohol: Choose an item. | I have ever used other substances: Choose an item. |

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| **My most recent hospital visit** |  | **My current supports and services** |
| Last updated: | Last updated by: |  | Last updated: | Last updated by: |
| Hospital name: |  | Organization | Start date |
| Type of visit: Choose an item. |  |  |  |
| Date of visit: |  |  |  |
| Date of discharge (if applicable): |  |  |  |
| Key advice from hospital: |  |  |  |