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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: | |  |  |  |