HealthLink _____'s Coordinated Care Plan (Detail) v1.0.0

My identifiers	Last verified: Click here.	Last verified by: .
Given name: .	Preferred name:	Surname: .
Gender: Choose an item.	Date of birth: YYYY-MM-DD	Health Link:
Address:		City:
Province: ON	Postal code:	Telephone #:
Health card #:	Issued by: Choose an item.	Alternate Telephone #:
Email address:	Preferred contact by: Choose an item.	Mother tongue:
Official language: Choose an item.	Ethnicity/culture:	Religion:
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: Choose an item.	Telephone #:
Emergency contact:	Relationship to me: Choose an item.	Telephone #:

My care team			Last verified: Click here.	Last verified by: .		
Care team member name	Role or relationship	Organization name	Telephone #	Regular care team member	Lead care coordinator	I rely on most at home
				Choose an item.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
The people I rely on most at home are feeling: Choose an item.						

My health issues			Last verified: Click here.	Last verified by: .	
Issue type	Description	Clinical description	Date of onset	Stability	Notes
Choose an item.			YYYY-MM-DD	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.	
Choose an item.				Choose an item.	
Choose an item.				Choose an item.	
Choose an item.				Choose an item.	
Choose an item.				Choose an item.	

Baseline vitals		
Height: ☐ cm ☐ in	Weight: ☐ kg ☐ lb	HbA1c: ☐ % ☐ mmol/mol

My known, current allergies and medications

Last verified: Click here. Last verified by: .

Allergies and intolerances

No known allergies (NKA): ☐

Be sure to review these allergies before treating the person

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.

Medications

Be sure to review these medications before treating the person

Date of last medication reconciliation: YYYY-MM-DD	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.				YYYY-MM-DD	YYYY-MM-DD	
		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.						
		Choose an item.						

Special notes or instructions:

My plan to achieve my goals for care

Last verified: Click here. Last verified 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	Suggested by	What we can do to achieve it	Who will be responsible	Expected outcome	Barriers and challenges	Results achieved so far	Review date
	Choose an item.						YYYY-MM-DD
	Choose an item.						

	Choose an item.						

My plan for future situations

Future situations	What I will do	What I will *not* do	Who will help me	Telephone #	Review date
					YYYY-MM-DD

I have received information about advance care planning: Choose an item.

I have a completed advance care plan: Choose an item. My ACP is located here:

As I understand it, my advance care plan says:

I have a Power of Attorney (POA) for personal care: Choose an item. My POA document is located here:

Name of POA attorney: Relationship to me: Choose an item. Telephone #:

My situation and lifestyle

Last verified: Click here. 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):

- ☐ Private Insurance
- ☐ Canada Pension Plan (CPP)
- ☐ Canada Pension Plan Disability (CPPD)
- ☐ Guaranteed Income Supplement (GIS)
- ☐ Ontario Disability Support Program (OSDP)
- ☐ Ontario Drug Benefits
- ☐ Ontario Guaranteed Income Supplement (GAINS)
- ☐ Ontario Works
- ☐ Special Service at Home (SSAH)
- ☐ Veteran's benefits
- ☐ Other
- ☐ Decline to answer

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. How adequate my housing is for 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: # of drinks/week:

I have ever used other substances: Choose an item.

Substance	How recently	How frequently
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.
Choose an item.	Choose an item.	Choose an item.

I gamble responsibly: Choose an item. Most recent date I gambled: # days in last 90 days:

I get 30 minutes of physical activity 5x/week: Choose an item.

I have had social interaction in the last 7 days: Choose an item.

Other considerations (e.g., sleep habits):

My recent health assessments

Last verified: Click here. Last verified by: .

Assessment type	Assessment name	Completed	Date completed	Score	Actions taken
Frailty		Choose an item.	YYYY-MM-DD		
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.			
Risk of falls		Choose an item.			

My most recent hospital visit

Last verified: Click here. Last verified by: .

Hospital name:	Type of visit: Choose an item.
Visit date:	Date of discharge (if applicable):
Reason for visit:	Complications:
Hospital physician name:	Hospital physician telephone #:
Key advice from hospital physician:	
Follow-up appointment made with:	Date of follow-up appointment:

My other treatments

Last verified: Click here. Last verified by: .

Significant surgeries and/or implanted devices (e.g. pacemaker, transplant, stent):	
Health education or counselling (e.g. group counselling):	Next planned date:
Assistive devices (e.g. oxygen cylinder, wheelchair):	
Self-monitoring routines (e.g. daily home blood pressure readings):	
Other treatments (e.g., traditional healer):	

My current supports and services

Last verified: Click here. Last verified by: .

Contact name	Organization name	Services provided	Telephone #	Email address	Start date

My appointments and referrals

Last verified: Click here. Last verified by: .

Date	Time	Provider name	Purpose	Notes