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v2.1

[Insert Name]'s Coordinated Care Plan

Last updated by:

Last updated date: **YYYY-MMM-DD**

Note: **This template must be completed in conjunction with the Coordinated Care Plan user guide.**

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:	
Language of comfort:	Communication accommodations:	

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:

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	

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

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)

More About Me	
Topics	Details
Income	
Employment	
Housing	
Transportation	
Food security	
Social network	
Health knowledge	
Newcomer to Canada	
Legal	
Spiritual affiliation	
Caregiver Issues	

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?):	

My Allergies	No known allergies ☐
What are you allergic or intolerant to?	What happens to you? What are your symptoms?

Appendices attached: ☐ **Medication List** ☐ **My Health Assessments** ☐ **Most Recent Hospital Visit** ☐ **Palliative Approach to Care**

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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)

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

My Health Assessments		
Assessment type and name	Date completed	Notes
	YYYY-MMM-DD	
	YYYY-MMM-DD	
	YYYY-MMM-DD	
	YYYY-MMM-DD	

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Appendix 3

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:		

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Appendix 4

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
Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem)		
Symptoms	Treatments	Comments
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:		