HealthLink
North East Toronto Health Link
Let's Make Healthy Change Happen

Health Links
Coordinated Care Plan Summary for Complex Adults

Last updated: _____ By: _____
(DD/MMM/YYYY)

Guiding Principles

I want to be involved in my care plan. I want information shared with my care team and me. Please:

- Ask for my opinion and speak in plain language
- Suggest a treatment plan
- Tell me if this (new treatment) will change the course of my condition
- Be honest about my prognosis and keep me informed about end-of-life options on a regular basis

1. Demographics:

Name: _____		OHN: _____		Version: _____
DOB: ____ (DD/MMM/YYYY)	Age: ____	Gender: ☐ M ☐ F ☐ TS/TG	Height: _____ cm	Weight: ___ kg
Address: _____ _____ ☐ Homebound			Home Phone: _____ Mobile Phone: _____	
Primary Language: ___		Interpreter Name: _____		Telephone: _____
Marital Status (☑): ☐ Single ☐ Married ☐ Divorced/Separated ☐ Common-Law ☐ Widowed				
Caregiver Name: _____		Phone: _____		Mobile Phone: _____
Relationship to Patient: _____				
Legal SDM: _____		Phone: _____		Mobile Phone: _____
Is the SDM also the POA?: ☐ Yes ☐ No		EMS DNR Confirmation Form #: _____		

2. My Care Plan Coordinator:

Name: _____	Phone: _____
Email Address: _____	

3. My Circle of Care Providers:

Provider:	Contact Information:	Role:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

4. My Current Health:

Health Conditions*:	Complications:	Stability *(frequency of treatment changes)*:
1.		☐ Stable ☐ Unstable
2.		☐ Stable ☐ Unstable
3.		☐ Stable ☐ Unstable
4.		☐ Stable ☐ Unstable
5.		☐ Stable ☐ Unstable
6.		☐ Stable ☐ Unstable

**includes physical and mental health, and social determinants of health*

HealthLink
North East Toronto Health Link
Let's Make Healthy Change Happen

Health Links
Coordinated Care Plan Summary for Complex Adults

Last updated: _____ By: _____
(DD/MMM/YYYY)

5. My Safety Net:

My immediate concerns are:

_____

My long-term concerns

_____

☐ I will call 911 if I experience: _____

_____

If at any time you feel it is an emergency and you need urgent assistance, call 911

☐ I do not want to call 911

If I experience (signs and symptoms):	I will (action to take):
1.	
2.	
3.	

6. My Advance Care Plan:

Questions to guide discussion:	My Advance Care Plan: *(patient's understanding of discussion)*
"Do you have an Advance Care Plan?" (If yes, where is it located?)	
"What do you understand about advance care planning and/or advance directives?"	
"Can you tell me what kinds of decisions you have made about your future care?"	
"One of the most important decisions we encourage all adults to make is to think about who they would choose to make decisions for them if something happened and they were no longer able to communicate their decisions. Do you have someone you might consider asking to take on this responsibility?"	
"We have some information here that I'd like to give you that will help you and your family/close friends to start talking and learning together." (Provide TC LHIN Advance Care Planning Workbook, Ministry Guide and Power of Attorney for Personal Care document)	
Arrange follow-up meeting with patient and chosen decision-maker	**Next meeting:** Date: _____ Time: _____ Location: _____ ☐ Declined ☐ Will revisit in 6 weeks

HealthLink
North East Toronto Health Link
Let's Make Healthy Change Happen

Quinte Health Links
Coordinated Care Plan Summary for Complex Adults

Last updated: _____ By: _____
(DD/MMM/YYYY)

7. My Care Goals:

My Current Goals:
I hope to: _____
_____
Anticipatory Care Questions:
When my heart and/or breathing stops, if someone close by is aware:
☐ I would want attempts made to restart my heart and/or breathing.
☐ I would **not** want attempts made to restart my heart and/or breathing.
If my condition(s) gets worse and it looks like I might not survive:
☐ I would like to be offered all investigations/treatments deemed reasonable to prolong my life.
☐ I would like to receive investigations/treatments that would only focus on my comfort.

8. My Life Goals:

Category:	Goal:
Assistance with understanding my care instructions *Are you having any difficulty understanding your care instructions?* *What would make it easier for you?* *(Provide examples of assistance available)*	
Assistance with my medications *Are you having any difficulty getting, organizing and/or taking your medications?* *What would make it easier for you?* *(Provide examples of assistance available)*	
Assistance with my nutrition *Are you having any difficulties getting and/or preparing nutritious food?* *What would make it easier for you?* *(Provide examples of assistance available)*	
Assistance with getting through the day and night *Are you having any difficulties getting through the day and/or night?* *What would make it easier for you?* *(Provide examples of possible solutions)*	
Assistance with my mental health *Have you been having any concerns about your mood (or thinking/remembering)?* *Have others expressed concern about your mood (or memory)?* *What would make it easier for you to feel better (or manage day to day)?*	

HealthLink
North East Toronto Health Link
Let's Make Healthy Change Happen

Quinte Health Links
Coordinated Care Plan Summary for Complex Adults

Last updated: _____ By: _____
(DD/MMM/YYYY)

8. My Life Goals (continued):

Category:	Goal:
Assistance with safe living *Are you having any challenges with living safely day to day?* *What would make it feel safer for you?* *(Provide examples of possible solutions)*	
Assistance with controlling my substance use *Are you having difficulties controlling your smoking (or drinking/drug use)?* *What assistance would you find helpful right now?* *(Provide examples of assistance available)*	
Assistance with supporting my circle of care *Do you have any concerns about those who help you on a regular basis?* *What assistance might be helpful to reduce these concerns?* *(Provide examples of assistance available)*	

9. My Activity Level:

Clinical Frailty Scale*:	My Usual Score: _____
 ❶ **Very Fit -** robust, active, energetic, motivated, exercise regularly	 ❻ **Moderately Frail -** need help with outside activities, keeping house, bathing
 ❷ **Well -** no active disease symptoms, less fit than category 1	 ❼ **Severely Frail -** completely dependent for personal care
 ❸ **Managing Well -** medical problems are well controlled, not regularly active	❽ **Very Severely Frail**
 ❹ **Vulnerable -** not dependent, symptoms limit activities	 ❾ **Terminally Ill -** life expectancy <6 months, not otherwise evidently frail
 ❺ **Mildly Frail -** more evident slowing, high order IADLs	8 or 9

**Rockwood et al. 2008*

10. My Action Plan (for my circle of care):

Action:	Who's Responsible:
1. Correct allergy list at hospital (likes sulfa & NOT allergic"	
2. Improve pain control	
3. Improve mobility	
4. DNR order completed today as directed by Velma	
5. Planning re options / LTC placement	

HealthLink
North East Toronto Health Link
Let's Make Healthy Change Happen

Quinte Health Links
Coordinated Care Plan Summary for Complex Adults

Last updated 25 June 2014 By: MW
(DD/MMM/YYYY)

11. My Medications:

Date last updated: _____ (DD/MMM/YYYY)	By: _____
My last medication changes were:	**It made me feel:**
1.	☐ Better ☐ Worse ☐ Same
2.	☐ Better ☐ Worse ☐ Same
Challenges I have with taking my medications: _____	
Dosette or compliance packaging: ☐ Yes ☐ No ☐ Other assistance: _____	
Allergies: hospital records state sulfa allergy but incorrect	Primary Care MD: _____
	Community Pharmacy: _____
	Pharmacy Telephone: _____

Drug Name	Date started (DD/MMM/YYYY)	Purpose	Dose	Form	Frequency	Notes (E.g. prescriber if different from usual; # doses/week if prn)
1.						
2.						
3.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

Please ensure ALL MEDICATIONS accompany you to the Emergency Department