

		CURRENT DATE	PLANNED DATE OF NEXT CARE PLAN REVIEW		
NAME OF PATIENT		TELEPHONE NUMBER	PERSONAL HEALTH NUMBER (PHN)		
NAME OF CAREGIVER		TELEPHONE NUMBER (PRIMARY)	TELEPHONE NUMBER (SECONDARY)		
NAME OF SUBSTITUTE DECISION MAKER		TELEPHONE NUMBER (PRIMARY)	TELEPHONE NUMBER (SECONDARY)		
NAME OF PRIMARY HEALTH CARE PROVIDER (E.G. GP)		TELEPHONE NUMBER (PRIMARY)	TELEPHONE NUMBER (SECONDARY)		
NAME OF SUPPORTING HEALTH CARE PROVIDER (1)		ROLE OR RESPONSIBILITY	TELEPHONE NUMBER		
NAME OF SUPPORTING HEALTH CARE PROVIDER (2)		ROLE OR RESPONSIBILITY	TELEPHONE NUMBER		
NAME OF SUPPORTING HEALTH CARE PROVIDER (3)		ROLE OR RESPONSIBILITY	TELEPHONE NUMBER		
<b>COMORBID CONDITIONS</b> ENDOCRINE <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroid MUSCULOSKELETAL <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis RESPIRATORY <input type="checkbox"/> Asthma <input type="checkbox"/> COPD RENAL <input type="checkbox"/> CKD GFR: _____ OTHER COMORBID CONDITIONS:		CARDIOVASCULAR <input type="checkbox"/> Hypertension <input type="checkbox"/> CAD <input type="checkbox"/> PVD <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> MI NEUROLOGICAL <input type="checkbox"/> Stroke	GASTROINTESTINAL <input type="checkbox"/> GERD <input type="checkbox"/> Ulcer <input type="checkbox"/> IBS/IBD <input type="checkbox"/> Constipation PSYCHIATRIC <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar	HEIGHT (in/cm) WEIGHT (lbs/kg) BMI PATIENT/FAMILY/CAREGIVER PRIMARY CONCERNS:	
<b>FRAILTY SCORING</b> PRISMA-7: <input type="checkbox"/> Score ≥ 3		MOBILITY TUG Test: <input type="checkbox"/> Time >10s	Gait Speed Test: <input type="checkbox"/> Time > 5s over 4m	COGNITIVE ASSESSMENT SMMSE: MoCA:	<b>CLINICAL FRAILTY SCALE</b> <input type="checkbox"/> 1: Very fit <input type="checkbox"/> 2: Well <input type="checkbox"/> 3: Managing well <input type="checkbox"/> 4: Vulnerable <input type="checkbox"/> 5: Mildly frail <input type="checkbox"/> 6: Moderately frail <input type="checkbox"/> 7: Severely frail <input type="checkbox"/> 8: Very severely frail <input type="checkbox"/> 9: Terminally ill
<b>PATIENT GOALS, VALUES AND PREFERENCES</b>		<b>STRATEGIES (INCLUDE REFERRALS MADE)</b>	<b>NOTES</b>		
<b>CARE PLAN DOCUMENTATION</b>		<b>CHECKLIST</b>	<b>DOCUMENTS COMPLETED</b>	<b>DATE COMPLETED</b>	
<b>MEDICATION REVIEW:</b>		<input type="checkbox"/> Medication review conducted or requested <input type="checkbox"/> Patient/caregiver/representative given copy of medication record	<input type="checkbox"/> Best Possible Medication History (see example <i>Associated Document</i> )		
<b>ADVANCE CARE PLANNING:</b>		<input type="checkbox"/> Discussed advance care planning <input type="checkbox"/> Provide <i>Advance Care Planning Resource Guide</i>	<input type="checkbox"/> Medical Order for Scope of Treatment (MOST) <input type="checkbox"/> No Cardiopulmonary Resuscitation form (HLTH 302.1)		
<b>CARE PLAN COMMUNICATION:</b>		<input type="checkbox"/> Care plan shared with patient/caregiver/representative <input type="checkbox"/> Provided <i>Patient and Caregiver Resource Guide</i>	Names/roles of persons present at care plan discussion:		

**AREAS OF ASSESSMENT**

**NOTES AND CONCERNS**

**RECOMMENDATIONS AND REFERRALS**

MEDICAL REVIEW		
<b>IMMUNIZATIONS</b> <input type="checkbox"/> Annual influenza <input type="checkbox"/> Td (or Tdap) booster <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Herpes zoster		
<b>HABITS</b> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol use <input type="checkbox"/> Sexual function <input type="checkbox"/> Substance use		<input type="checkbox"/> Refer to smoking cessation program
<b>NUTRITION</b> <input type="checkbox"/> Diet/appetite <input type="checkbox"/> Dentition <input type="checkbox"/> Weight loss <input type="checkbox"/> Obesity <input type="checkbox"/> Swallowing		<input type="checkbox"/> Direct to HealthLinkBC dietitian services (8-1-1) <input type="checkbox"/> Provide Resource Guide section on Nutrition Referral to: <input type="checkbox"/> dietitian <input type="checkbox"/> swallowing assessment
<b>BOWEL AND BLADDER</b> <input type="checkbox"/> Bladder or bowel incontinence <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea		<input type="checkbox"/> Medication review for bowel/bladder problem drugs <input type="checkbox"/> Implement bowel protocol <input type="checkbox"/> Referral to Nurse Continence Advisor, if available
<b>PERCEPTION AND COMMUNICATION</b> <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Hearing		Referral to: <input type="checkbox"/> optometrist <input type="checkbox"/> ophthalmologist <input type="checkbox"/> audiologist <input type="checkbox"/> speech therapist
<b>PAIN</b>		<input type="checkbox"/> Direct to www.PainBC.ca
PSYCHOLOGICAL REVIEW		
<b>COGNITION</b> <input type="checkbox"/> Memory <input type="checkbox"/> Executive function <input type="checkbox"/> Delirium <input type="checkbox"/> Behavioural issues <input type="checkbox"/> Capacity assessment	MoCA Score: _____ SMMSE Score: _____	<input type="checkbox"/> Provide Resource Guide section on Managing Chronic Conditions
<b>MOOD</b> <input type="checkbox"/> Depression <input type="checkbox"/> Irrational fears <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep problems		
FUNCTIONAL REVIEW		
<b>MOBILITY</b> <input type="checkbox"/> Gait and speed <input type="checkbox"/> Balance <input type="checkbox"/> Mobility aids <input type="checkbox"/> Foot care/footwear	Gait Speed Test: _____ TUG Test: _____	<input type="checkbox"/> Provide Resource Guide section on Physical Activity Referral to: <input type="checkbox"/> physical therapy <input type="checkbox"/> occupational therapy
<b>FALL RISK</b> <input type="checkbox"/> Fall history <input type="checkbox"/> Fall prevention <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Alert device		<input type="checkbox"/> Provide Resource Guide section on Fall Prevention <input type="checkbox"/> Review medications for drugs that increase fall risk
<b>PHYSICAL ACTIVITY</b> <input type="checkbox"/> Activity level <input type="checkbox"/> Exercise program <input type="checkbox"/> Fatigue and energy level <input type="checkbox"/> Endurance and strength		<input type="checkbox"/> Provide Resource Guide section on Physical Activity <input type="checkbox"/> Direct to HealthLinkBC Physical Activity Line (8-1-1) Referral to: <input type="checkbox"/> community balance or exercise program <input type="checkbox"/> physical therapy <input type="checkbox"/> occupational therapy
<b>BASIC ACTIVITIES OF DAILY LIVING</b> Bathing: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Dressing: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Toileting: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Transfers: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Feeding: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP		<input type="checkbox"/> Referral to Home and Community Care
<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b> Cooking: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Medications: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Cleaning: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Banking: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Shopping: <input type="checkbox"/> IND <input type="checkbox"/> ASST <input type="checkbox"/> DEP Driving: <input type="checkbox"/> IND <input type="checkbox"/> CONCERN <input type="checkbox"/> DEP		<input type="checkbox"/> Referral to Home and Community Care <input type="checkbox"/> Consider driving fitness assessment
SOCIAL AND ENVIRONMENTAL REVIEW		
<b>SOCIAL AND SPIRITUAL NEEDS</b> <input type="checkbox"/> Hobbies/interests <input type="checkbox"/> Social activities <input type="checkbox"/> Isolation/loneliness <input type="checkbox"/> Spiritual needs		<input type="checkbox"/> Provide Resource Guide section on Social Support <input type="checkbox"/> Referral to Spiritual Care or community group
<b>CARE SUPPORT</b> <input type="checkbox"/> Informal support from family/friends <input type="checkbox"/> Caregiver stress <input type="checkbox"/> Access to local resources/services <input type="checkbox"/> Eligibility for formal support		<input type="checkbox"/> Provide Resource Guide section on Caregiver Support <input type="checkbox"/> Referral to Home and Community Care
<b>MANAGING AT HOME</b> <input type="checkbox"/> Home comfort and safety <input type="checkbox"/> Elder abuse <input type="checkbox"/> Medical equipment/supplies at home <input type="checkbox"/> Financial or legal concerns		<input type="checkbox"/> Provide Resource Guide section on Help at Home <input type="checkbox"/> Referral to Home and Community Care <input type="checkbox"/> Direct to SeniorsFirstBC.ca if elder abuse suspected