Patient Name:	Preferred Name:
AB Health Card No.:	Date of Birth:
Primary Care Provider:	Primary Provider Contact No.:
Emergency Contact:	Contact No.:

This document was created on: *and last updated on:*

Introduction to Your Care Plan and Care Planning Visit

During the course of this visit, this document (called a care plan) will be filled out by you and your health care team. A care plan is useful when you have several people involved in your care or you have ongoing health conditions. It helps keep everyone on the 'same page' as to what matters to you (your goals, values and preferences). It also helps keep track of what you and your healthcare team have planned or are working on for the next 12 months to improve your health and wellbeing.

It is designed to help everyone involved in your health to know:

PART A: Medical Summary

In order to better understand your health conditions and how you are currently managing them, questions about your health, medications, medical history, and treatments, etc. are discussed in the section below.

Current Health Conditions

Please name your current health conditions. What do you know about them? What more would you like to know about them?

Impact of Health Conditions

How do your health conditions impact you, your daily life and the things that are important to you (e.g., medication cost, personal and work obligations, transportation)?

Health Target(s)

Specific tests are used to help understand whether a health condition is well managed. Understanding where your numbers are now and what you can work towards will help ensure you can achieve what is important to you.

Test Results	My Current Number	Where I Need to be
BMI (height and weight calculation)		
Blood Pressure (BP)		

Current Medications

Please name the medications you are currently taking. How and why do you take them?

Medication	Dosage	When I Take It	What I Take it For

Past Medications

Are there any medications that you have taken in the past that you want your doctor to be aware of (e.g., failed medications or cases where one medication was replaced with another medication)?

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Allergies and Intolerances

Your records show that the following are your allergies and intolerances. Is there anything that should be added?

No Known Allergies ☐	Reaction	Severity
		Mild
		Mild
		Mild

Family Medical History

In previous appointments you have shared the following family medical history. Is there anything that should be added?

Condition(s)	Relation

Significant Historical Medical Events

Your records show the following history of medical events. Is there anything that should be added? Include surgical history, hospitalizations or emergency visits in the last 2 years.

Medical Event	Date

Other Team Members Seen for Tests and / or Treatments

What other tests or treatments do you receive from health team members outside of this clinic? Include all tests and treatments and the corresponding health care team member information e.g., specialists, chiropractor, physiotherapist, etc.

Name of Test or Treatment	Frequency and/or Date	Health Team Member Name	Contact Number

Modifiable Lifestyle or Risk Factors

Specific lifestyle or risk factors, such as tobacco use, regular physical activity and diet can impact a person's health. Is there anything that you would like to share with me about what you are doing well in these areas or what you would like to improve?

Areas where doing well:	Areas for improvement:

What is your smoking status?

Non-smoker ☐ Ex-smoker ☐ Smoker with desire to quit ☐ Smoker actively quitting ☐

Smoker with no plans to quit at this time ☐ Other ☐ Specify:

Comments: *(e.g., if ex-smoker, length of time since quitting, type of product smoked)*

Medical and Assistive Devices

Are you currently using any medical or assistive devices?

None ☐ Wheelchair ☐ Oxygen ☐ Other ☐ Specify:

Advance Care Planning

Have you thought about, talked about with family and friends and written down wishes for your health care in the event that you are incapable of consenting to or refusing treatment or other care? Would you be interested to have guidance or assistance to prepare a personal care directive?

I have a personal care directive Yes ☐ No ☐	I have a Power of Attorney Yes ☐ No ☐

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Do you have your goals of care documented? Yes ☐ No ☐

Comments:

Insert relevant information such as goals of the care designation, power of attorney contact information, etc.

PART B: Social History

Now that you have provided your medical history, this section captures other aspects of your life that may impact your ability to manage your health such as your finances, housing, and support systems. Is there anything in those areas that are impacting your health?

Do you ever have difficulty making ends meet (paying your bills) at the end of the month? Is there anything about your current employment situation or finances that would impact your health and wellbeing? Who covers the cost of medications and other services?

Is there anything you would like your care team to know about your housing situation? Do you feel safe where you live?

Do you feel you have enough support at this time to manage your health? Can you tell me more about your supports? Are there any community resources or services that you use (e.g., transportation services, food services, group support meetings, etc.)?

PART C: Goals and Action Plan

The section below builds on the information you've provided above by capturing some potential goals and actions that can be taken to better manage your health and improve your quality of life.

What you want to achieve and why it is important to you

Please share what matters to you personally and what you want to achieve so you have the best quality of life and health outcomes.

e.g., I want to have my diabetes managed (A1C below 8) so I can travel to Ottawa in the fall for my daughter's wedding.

Where you need to start

There are a number of areas you can work on to achieve your goal(s) listed above. The list below helps to determine what area is the highest priority for you.

Priority (1=lowest priority; 5=highest priority. The same number can be assigned more than once.)

1. Monitor and manage symptoms (e.g., pain, dizziness, weakness, blood sugars)	◯1	◯2	◯3	◯4	◯5	◯N/A
2. Engage in specific treatment activities (e.g., physiotherapy, foot care, mental health, wounds)	◯1	◯2	◯3	◯4	◯5	◯N/A
3. Attend services and appointments (e.g., lab work, specialist, education sessions)	◯1	◯2	◯3	◯4	◯5	◯N/A
4. Monitor and manage triggers and risk factors (e.g., alcohol, tobacco, recreational drugs, stress)	◯1	◯2	◯3	◯4	◯5	◯N/A
5. Monitor and manage healthy lifestyle factors (e.g., physical activity, nutrition, mood, social support)	◯1	◯2	◯3	◯4	◯5	◯N/A
6. Manage medications (e.g., right dose, side effects, medication review)	◯1	◯2	◯3	◯4	◯5	◯N/A

Action Plan

What specific actions you need to take to achieve your goal(s)
(SMART Goal – Specific, Measurable, Attainable, Realistic, Timely)**:**

e.g., I will work on monitoring and managing my symptoms. I will do this by checking my blood sugar every morning before breakfast. I write down my result in my log book so I can work towards my A1C coming down and be able to go to my daughter's wedding.

	Is there anything you think of that might get in your way? How could you work around these things?
	e.g., I will need to set a regular reminder on my cell phone to remember to check my blood sugar each morning before breakfast and I will put my log book beside my glucometer so I remember to write my numbers down.
	How confident are you that you can achieve the above goal and action plan?

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○
Low				Medium					High

We (the physician and patient/agent) have discussed this care plan and the patient/patient agent has received a written copy of it. A similar document has not been completed with another physician in the past twelve months.

Date (yyyy/mm/dd)	Patient and/or Agent Name	Patient or Agent Signature
Date (yyyy/mm/dd)	Physician Name	Physician Signature