HealthLink

HealthLink's Coordinated Care Plan (Summary)

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:
Health card #:	Issued by: Choose an item.	Telephone #:
Official language: Choose an item.	Ethnicity/culture:	Religion:
Mother tongue:	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	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.	☐	☐

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.	

Frailty assessment score:	Assessment name:	Date of assessment:

My allergies, medications and treatments 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:

HealthLink

HealthLink's Coordinated Care Plan (Summary)

v1.0.0

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.						

Special notes or instructions:

Significant surgeries and/or implanted devices (e.g. pacemaker, transplant, stent):

Assistive devices (e.g. oxygen cylinder, wheelchair):

My plan to achieve my goals for care

Last verified: Click here. Last verified by: .

What is most important to me right now:

What concerns me most about my healthcare right now:

What I hope to achieve	What we can do to achieve it	Who will be responsible	Barriers and challenges

My plan for future situations

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 smoke tobacco: Choose an item. I drink alcohol: Choose an item. I have ever used other substances: 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):

Key advice from hospital physician:

My current supports and services

Last verified: Click here. Last verified by: .

Organization name	Start date