My identifiers	Last updated:	Last updated by:
Given name:	Preferred name:	Surname:
Gender: Choose an item.	Date of birth:	OHIP insured: Choose an item.
Address:	City:	Health card #:
Province:	Postal code:	Preferred contact by: Choose an item.
Telephone #:	Alternate telephone #:	Email address:
Mother tongue:	Preferred official language: Choose an item.	Ethnicity/culture:
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:	
Substitute decision maker (SDM):	**SDM telephone #:**	
Emergency contact:	**Emergency contact telephone #:**	

My plan to achieve my goals for care	Last updated:		Last updated by:				
Care team members who contributed to this plan:							
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	Expected outcome	Confidence will achieve	Barriers and challenges	Results so far	Review date

My plan for future situations					
When my heart/breathing stops, if someone is close by, I would want them to: Choose an item.					
If my condition(s) get worse and it looks like I might not survive, I would like to: Choose an item.					
Future situations	What I will do	What I will *not* do	Who will help	Telephone #	Review date

My care team		Last updated:		Last updated by:		
Name	Role or relationship	Organization	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.	☐	☐
				Choose an item.	☐	☐
				Choose an item.	☐	☐
The people I rely on at home are: Choose an item.						

My health conditions		Last updated:		Last updated by:	
	Condition description	Condition	Date of onset	Stability	Notes
Physical Health				Choose an item.	
				Choose an item.	
				Choose an item.	
				Choose an item.	
Mental Health				Choose an item.	
				Choose an item.	
				Choose an item.	
				Choose an item.	
Other (e.g. social) Factors				Choose an item.	
				Choose an item.	
				Choose an item.	
				Choose an item.	

Baseline vitals		
Height: *m* *in*	Weight: *kg* *lb*	HbA1c: *%*

Allergies and intolerances			
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.

My situation and lifestyle	Last updated:	Last updated by:	
How I work: Choose an item.	How adequate my income is for my health: Choose an item.		
Supplementary benefits I receive: Choose an item.	Choose an item.	Choose an item.	Choose an item.
I follow my recommended diet: Choose an item.	How adequate my food is for my health: Choose an item.		
How I travel: Choose an item.	How difficult it is to travel: Choose an item.		
How difficult it is to read and understand information about my health: Choose an item.			
I smoke tobacco: Choose an item.	# of cigarettes/day:	# of pack years:	Quit date:
I drink alcohol: Choose an item.	# of drinks in one sitting: Choose an item.	# of drinks/week:	
I have ever used other substances: Choose an item.	Which: Choose an item.	How often: Choose an item.	
I get 30 minutes of physical activity 3x/week: Choose an item.			
Other considerations (e.g. sleep habits):	Group memberships (e.g. religious, social, etc):		

My assessed health needs	Last updated:		Last updated by:		
Assessment type	Assessment name	Completed	Date completed	Score	Actions taken
Frailty		Choose an item.			
Health literacy		Choose an item.			
ADL		Choose an item.			
IADL		Choose an item.			
Pain		Choose an item.			
Hospital re-admission risk		Choose an item.			
Cognition		Choose an item.			
Aggressive behaviour		Choose an item.			
Risk of self-harm		Choose an item.			
Mood		Choose an item.			

My most recent hospital visit	Last updated:	Last updated by:
Hospital name:		Type of visit: Choose an item.
Date of visit:		Date of discharge (if applicable):
Reason for visit:		Complications:
Name of hospital physician:		Telephone #:
Key advice from hospital physician:		
Follow-up appointment made with:		Date of follow-up appointment:

My current supports and services	Last updated:		Last updated by:			
Contact name	Organization	Services	Telephone #	Email address	Start date	End date

My known, current medications	Last updated:	Last updated by:
Date of last medication reconciliation:		Performed by:
My last medication change was:		It made me feel: Choose an item.
Aides I use to take my medications: Choose an item.		Challenges I have taking medications:

Drug name	Strength	Route	Frequency	Reason	Pharmacy	Start date	Change date	Prescriber

My other treatments	Last updated:	Last updated by:
Surgical devices or changes (e.g. pacemaker, transplant, stent):		
Health education or counselling (e.g. MedsCheck or group counselling):		Next planned date:
Assistive devices (e.g. oxygen cylinder, wheelchair):		
Self-monitoring routines (e.g. daily home blood pressure readings):		
Other treatments:		

My top 5 daily routines	Last updated:		Last updated by:
Time of day	What I will do	Contact for questions	Contact's telephone #
Morning			
Afternoon			
Evening			
Overnight			

My appointments and referrals	Last updated:		Last updated by:	
Date	Time	Provider name	Purpose	Notes