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: <INSERT DATE> and last updated on: <UPDATE DATE>

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

Current Health Conditions

Impact of Health Conditions

Health Target(s)

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

Current Medications

Medication	Dosage	When I Take It	What I Take it For

Past Medications

Allergies and Intolerances

No Known Allergies ☐	Reaction	Severity
		Mild
		Mild
		Mild

Family Medical History

Condition(s)	Relation

Significant Historical Medical Events

Medical Event	Date

Other Team Members Seen for Tests and / or Treatments

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

Modifiable Lifestyle or Risk Factors

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:

Medical and Assistive Devices

None ☐ Wheelchair ☐ Oxygen ☐ Other ☐ Specify:

Advance Care Planning

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

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

Comments:

PART B: Social History

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.)?

Patient Name: _____ *Preferred Name:* _____

Alberta Health Care No.: _____ *Date of Birth:* _____

PART C: Goals and Action Plan

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

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)**:**

Is there anything you think of that might get in your way? How could you work around these things?

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