**My Care Plan**

Photo (optional)

Name: ……………………………………………………………

Address: …………………………………………………………

Phone: ………………….Mobile:…………………Email: …………………………

NHI number: ……………………………Date of Birth: ……………………….

**My healthcare team** (list key people such as GP, nurse, specialist, pharmacist, nurse specialist, community health worker here)

|  |  |
| --- | --- |
| **Role**  | **Name & Contact Details** |
| Care Coordinator  |  |
| Nurse |  |
| Doctor |  |
| Specialist |  |
| Pharmacist |  |
| Nurse specialist |  |
| OT/Physiotherapist  |  |
|  |  |
|  |  |
|  |  |
| After Hours Number |  |
| Emergency Number |  |
| What I would like from my healthcare team is:  |

## Our plan to work together

The main reason for this care plan is to help me keep as well as possible. It is designed to help everyone involved in my health to know:

* about my health conditions
* what is important to me
* what **my goals** are for the next 12 months
* the main decisions my health providers and I have made about the healthcare and support I need

I understand regular health checks are important and I will attend these appointments as agreed.

I agree to work with my General Practice team and that costs have been discussed with me.

I have read and understand the information relating to what happens to my information.

|  |  |
| --- | --- |
| Agreed by: | Healthcare Team Member |
| My Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family Member (if applicable) | Designation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## About Me & My Family/Whanau

My preferred language is: …………………...Interpreter needed: Yes/No

The key people or family/whanau **I want** to include in any decisions about my health and care plan are:

1. ……………………… Relationship: ……………. Ph: …..............
2. ……………………… Relationship: …………….. Ph: ………….…
3. ……………………… Relationship: …………….. Ph: ………......

**I learn best from: (describe what helps, eg stories, pictures, ….)**

**Issues that make things harder for me at times are:**

🞏 My hearing 🞏 Filling-in forms

🞏 My vision 🞏 My mobility

🞏 Reading or writing 🞏 Money problems

🞏 Transport 🞏 Mood & feelings

🞏 Pain 🞏 Other (please explain)……………………

**Social History**

|  |
| --- |
| Who lives at home:  |
| **Work:** (Circle one) I am working full-time / part-time / unemployed / sick leave / retired  |
| **Smoking History:** Never smokedCurrent smoker: …………../day Ex-smoker – quit in …………  |
| **Alcohol:** (number of units per week) …………………. |
| **Physical Activity:** (type & time) |

## My Health Conditions

1. …………………………………………………………..
2. …………………………………………………………..
3. …………………………………………………………..
4. …………………………………………………………..
5. …………………………………………………………..
6. ………………………………………………………….
7. …………………………………………………………..
8. …………………………………………………………..
9. …………………………………………………………..
10. ……………………………………………………………

## Other Issues or Problems that I have

1. …………………………………………………………..
2. ………………………………………………………….
3. …………………………………………………………..

## My Priorities

We all have different values and priorities. It can be helpful to write these down and share with your healthcare team.

**The things that are most important to me are: Score (1 – 10)**

………………………………………………………………………..

………………………………………………………………………..

………………………………………………………………………..

**What worries or concerns me most is: Score (1 – 10)**

………………………………………………………………………..

………………………………………………………………………..

………………………………………………………………………..

##

## Thinking Ahead - My Goals & Action Plan

In the next 2 to 5 years my longer term goal is to:

…………………………………………………………………..

……………………………………………………………………

### How to get there

**Brainstorm and list ideas and smaller steps to help me reach my goal(s):**

…………………………………………………………………..

……………………………………………………………………

…………………………………………………………………….

|  |
| --- |
| From this list, my goal for the next 3 – 6 months is: (Aim to make this a SMARTER goal which is specific, measurable, action-based, realistic, timely, enjoyable, record/review and reward) |

### My confidence that I can achieve this goal is: (circle scale below)

0 1 2 3 4 5 6 7 8 9 10

0 = No confidence Somewhat confident 10 = Very confident

## Medical History

Use this page to list any major illnesses, time in hospital, operations and investigations such as CT scans, colonoscopy, ultrasounds and more.

|  |
| --- |
| **Past History**  |
| Date | Location | Details |
|  |  |  |
|  |  |  |
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## My Medication List

(Also include puffers, eye drops, vitamins, supplements, herbal/rongoa products)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of medicine** | **Strength**  | **How much to take and when** | **What it is for** | **Comments** |
|  |  | Breakfast | Lunch | Dinner | Bedtime |  |  |
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| Talk with your doctor, nurse or pharmacist before stopping any medicines. |

## Allergies or Medical Alerts

To ensure the medicine, food and advice you receive are safe for you

1. ……………………………………………………………..
2. ……………………………………………………………..
3. ……………………………………………………………..
4. ……………………………………………………………..

##

## Past Medications

List medicines that have been tried before and why they were stopped.

1. ………………………………………Why………………………..
2. ………………………………………Why………………………..
3. ………………………………………Why………………………..
4. ………………………………………Why………………………..
5. ………………………………………Why………………………..

## Other Notes

………………………………………………………….…….……..

……………………………………………………………………....

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##

## Planning Ahead – My 12 month Plan

List the key issues, goals and steps we have identified to improve my health over the next 12 months.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Issue** | **Goals & Action Steps (what / how)** | **Who** | **When** | **Review Date & Progress** |
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## Visit Planner

Use this page to list when you are due to visit members of your healthcare team. This can help with coordination and communication.

|  |  |  |
| --- | --- | --- |
| **Visit**  |  | **Fill in regular checks & appointments** |
|  | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Total |
| GP/nurse Visits |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Care Plan Annual review |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Specialist |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Dietitian |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Eye check |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dentist |  |  |  |  |  |  |  |  |  |  |  |  |  |

Sometimes some visits can be combined simply by seeing it written down like this.

## Visit Summary

To help everyone stay on the same page, write a brief summary of each visit here.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date**  | **With Whom** | **Brief Summary** | **Next Appt** |
|  |  |  |  |
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## My Log

Here I can record my recordings or blood tests such as blood pressure, weight, peak flow, blood sugars, warfarin level, uric acid, cholesterol etc.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Weight** | **BP** | **Lipids** |  |  |  |
|  | Target | Target | Target |  |  |  |
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## My Questions

Write down any questions you or your family / whanau have for the Doctor or Nurse

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## What Happens With My Health Information?

**How much of my information is shared?**

In order to assist you with your care, it is usual for healthcare providers to share certain information when making referrals, sending letters or asking a colleague for advice. This can include:

* Identification information such as name, date of birth, and National Health Index Number (NHI)
* Specific details on your condition such as examination findings and test results.

A detailed list of what information is collected is available from your care team and can be discussed with you, if you wish.

**Who else can access my information, and why?**

At a Primary Health Organisation (PHO) or District Health Board level grouped information about a large number of patients, in which you cannot be identified, may be used for programme evaluation, research and analysis to guide further developments of various programmes and service delivery for people with your condition(s); and will be used to produce statistics for health monitoring, planning and management purposes.

**What happens if I do not wish my information to be used in this way?**

You will receive the normal care you have always received, and this will not be reduced in any way. You still have access to all services, such as Emergency Care and the hospital, but they may not be in a position to know what has been happening with your condition recently.

**Who carries responsibility for managing my information?**

The group responsible for the data is the Primary Health Organisation (PHO) to whom your GP belongs. This group can be contacted through your General Practitioner.

# **Next Steps & More Information**

As you become more confident about steps you can take to keep well, you may wish to check out some other places for useful information.

**Health Navigator NZ**

* This is a great place to start when looking for trusted health information. From here, you can link through to key resources from all over New Zealand and the world about common health conditions. [www.healthnavigator.org.nz](http://www.healthnavigator.org.nz)

**Healthy Recipes**

* [www.healthnavigator.org.nz/](http://www.healthnavigator.org.nz/)
* Healthy Food Guide [www.healthyfood.co.nz/](http://www.healthyfood.co.nz/)

**Quit Smoking**

* Quit Line - [www.quit.org.nz](http://www.quit.org.nz)

**Managing Pain**

* Download the Pain Self-Care Toolkit
* Review Pain Self-Care website

**Action Plans**

* [www.healthnavigator.org.nz/](http://www.healthnavigator.org.nz/)

**Support Networks**

* [www.healthnavigator.org.nz/](http://www.healthnavigator.org.nz/)

# **Section B: Condition-Specific Sections**

### Condition Specific Patient Resources

* See Health Topics for wide range of topics, resources, action plans, and self-care tools at [www.healthnavigator.org.nz/](http://www.healthnavigator.org.nz/health-topics/)