Patient Name: **Harry Potter**
PHN: **123450 6789**
DOB: **January 1st, 2030**
Primary Care provider: **Dr. Albus Dumbledore** Contact #: **123.456.7890**
Emergency Contact: **Mr. Sirius Black** Contact #: **123.456.7890**
This document was last updated on: *<Today's Date>*

Your Shared Primary Care Plan

A care plan is a collection of health information that provides a picture of a person's health at any given point in time. This document (called a Shared primary 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' about what matters to you. It also helps keep track of what you and your healthcare team have planned or are working on to support you. Individual questions or sections may be left blank depending on circumstances or not required.

Medical Summary

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.

Your Current Health Conditions

What is Worrying you Right Now?

What are your biggest fears and worries about your health now and in the future?

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

Do you have any wishes, preferences or personal goals for your care? Have you made any key decisions about your health?

What do I need to know about you to help me give you the best possible care and advice? What is important for your care providers to know about you when considering treatment options? Are there some very important things you WANT TO HAPPEN or DO NOT WANT TO HAPPEN if your health situation worsens?

Who is in Your Health Care Team

Who are the people that help you and what do they help you with? This helps the different team members know who is doing what and how to contact each other for further information about you.

Team member/ Discipline	Contact Number
i.e. Dr. John Smith, Cardiologist (Heart Doctor)	*123-456-7890*
i.e. Jane Allen, Caregiver/ Mom	*123-456-7890*

Your Current Prescribed Medications/ Including Over the Counter Medications (i.e. Tylenol/ Advil)

Medication	Dosage and Frequency
Comments or special instructions:	

Your Allergies and Intolerances – No Known Allergies ☐

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

Allergy	Reaction / Severity

Your Significant Family Medical History

Your primary care provider has collected this family history. Is there anything that should be added?

Condition(s)	Relation

Your Significant Personal 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

Modifiable Factors

Many things can affect a person's health e.g., tobacco use, alcohol use and regular exercise and/or what you eat. Is there anything that you would like to share in some of these areas that you are doing well in or would like help with?

Things I do well:	Things I could use help with:

Your Home Supports

Are you currently using any assistive devices or other supports in your home?

None ☐ Mobility Aid ☐ Oxygen ☐ Other ☐ Specify ____________________________

Your 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? Yes ☐ No ☐

I have a personal care directive Yes ☐ No ☐ **Contact:**	I have a Power of Attorney Yes ☐ No ☐ **Who is it?**
Do you have your goals of care documented? Yes ☐ No ☐	**What is the designation? Drop down menu**
Is there a guardianship order in place? Not Applicable ☐ Yes ☐ No ☐ Effective Date: **Who is the guardian?**	
Do you wish to donate your organs if possible? Yes ☐ No ☐	
Comments: *Are there important decisions you have made during advance care planning?*	

Your Social History

This section captures other aspects of your life that may affect your ability to manage your health such as your finances, living situation and support systems. Is there anything in those areas that are impacting your health?

Financial: <Free text>
Living Situation: <Free text>
Support System: <Free text>
Care Giving: <Free text>
Comments: *Insert relevant information related to any aspects of your life that may impact your ability to manage your health.*

Your Action Plan

What specific actions you will take to achieve your goal(s) and/or manage your symptoms?
(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 hemoglobin 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.

Declaration

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

I am aware that this care plan will be kept by my primary care provider and a copy will be shared to my Alberta Netcare record to support my care in the Alberta health system.

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