CVC Program Patient friendly version of the Care Plan

Personal Details

Family name	First Name	Date of Birth
Address		Phone
DVA Gold Card No.		Medicare No.

Health Professionals	Phone	Address
Doctor		
CVC Care Coordinator		
DVA Community Nursing Provider		
Pharmacist		

Medication Record [include prescription and non-prescription]

Generic or Trade Name and Type	Dose	Frequency					Prescribing Doctor/ Reason for medicine	Commenced	Ceased
		M	L	D	N	PRN			

Planned Service Provider/ Education Contact	Details	No. per year	Scheduled services are to be shown under respective months listed below Care Plan commenced ____/____/____ Care Plan expiry date ____/____/____											
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
GP Consultations															
Care Plan Reviews															

Veteran Problem Statement	How much of a problem is this for me? 0 1 2 3 4 5 6 7 8 Not at all very little somewhat a fair bit a lot
Veteran Goal Statement	My progress towards achieving this goal 0 1 2 3 4 5 6 7 8 No success 25% 50% 75% complete success

Identified issues (including self-management)	What I want to achieve	Steps to get there	Who is responsible	Review date	Progress (e.g. no progress, some progress, completed)

SYMPTOM ACTION PLAN

What is it? The Symptom Action Plan is designed to help you and your doctor and care coordinator to manage your illness.
The Symptom Action Plan identifies the action you should take when these signs appear.

If the state of your illness or course of treatment changes, you can use the Monitoring Diary to write down the details. This information can then be used to decide what modifications need to be made to your Symptom Action Plan.

Who completes the forms? The Symptom Action Plan is to be completed by your doctor or care coordinator.

How do I use it? Veterans can carry the Symptom Action Plan with them (i.e. wallet or handbag) or place it on their fridge, so that they can refer to it, at any time, as the need arises.

If in doubt? If for any reason you are in doubt about what to do, then contact your doctor or care coordinator for advice. If they are unavailable, then contact the Emergency Department of your local hospital.

SYMPTOM ACTION PLAN **Date completed: ___/___/___** **Date to be reviewed: ___/___/___**

Veteran's name_____ DOB ___ / ___ / ___ Gold Card No._____

Admissions during past 2 years_____

_____

☐ Social – home environment e.g. falls

☐ Medication – not taking medication as prescribed e.g. cost, forgetfulness, side effects etc.

☐ Other_____

My primary condition is _____

I measure and manage my symptoms in the following way

When /If_____then I _____

When /If_____then I_____

When /If_____then I_____

When /If_____then I_____

When /If_____then I_____

If unsure, contact your doctor or care coordinator or the Emergency Department of your local hospital

	Name	**Phone**	**Address**
Doctor			
CVC Care Coordinator			
Hospital	Emergency Department		