CVC Program Comprehensive Care Plan

Personal Details

Title	**Family name**	**First Names**	**Date of Birth**___/___/___	**Age**
Address			**Phone**	
DVA Gold Card No.	**Resuscitation Order** Yes ☐ No ☐ N/A ☐ If yes, provide details **Advanced Health Directive** Yes ☐ No ☐ N/A ☐ If yes, provide details		**Aboriginal** ☐ **Torres Strait Islander** ☐	**HRN**
Medicare No.	**Power of Attorney / Enduring /Authority / Administration appointed?** [please specify] Yes ☐ No ☐ N/A ☐ If yes, provide details			

	Phone	**Address**
Carer		
Emergency Contact		
Doctor		
DVA Community Nursing Provider		
Pharmacist		

	Diagnosis	**Management**	**Target**	**Red flags**	**Review date**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8					

Allergies (or Nil Known)		**Reaction**	**Allergies (or Nil Known)**		**Reaction**
1.			4.		
2.			5.		
3.			6.		

Hospital Admissions / A&E Department Visits	**Admitted**	**Discharged**	**Reason for Presentation**	**Complications**

Devices	**Commenced**	**Devices**	**Commenced**

Medication Record [include prescription and non-prescription]

Home Medicines Review in the last 12 months: Yes ☐ No ☐ N/A ☐ If yes, provide details:

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

Recent results and investigations

Bloods	Results	BP	Urinalysis	Date	Next Due
			Vaccinations	**Date**	**Next Due**

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. none, some or completed)

I …… (Veteran) agree that the information contained within this Care Plan is correct and currently reflects my needs for the coming year. I consent to this information being released to my care team. Signature: _____Date: _____/_____/_____

I …… (GP) agree that the services prescribed within this Care Plan are correct at the time of development but are subject to review based on the veteran's needs and / or my opinion as the responsible Medical Practitioner. Signature: _____
_____Date: /_____/_____

Care Plan Review Date: _____/___/____

Patient friendly version supplied to veteran ☐

Care coordinator .....

MBS ITEMS: GP Management Plan - 721 ☐

Team Care Arrangements - 723 ☐

CVC UP01 ☐

CVC UP02 ☐

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 year _____

Reason for admission:_____

☐ 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_____

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