CVC Program Comprehensive Care Plan – Gold Card Holders

Personal Details

Title	Family name	Given Names	Date of Birth	Age
Address			**Phone**	
DVA Gold Card No.	**Resuscitation Order** ☐ **Yes** ☐ **No** ☐ **N/A** **If yes, provide details** **Advance 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			

	Name	Contact details
Carer		
Emergency Contact		
Doctor		
DVA Community Nursing Provider		
Pharmacist		

	Diagnosis	Management	Target	Red flags	Review date
1.					
2.					
3.					
4.					
5.					

	Allergies	Reaction		Allergies	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]

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

Home Medicines Review in the last 12 months ☐ **Yes** ☐ **No** ☐ **N/A**

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 commencement date: Care Plan expiry date:												
			Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
GP Consultations															
Care Plan Reviews															
Nurse Reviews															
Allied Health Appointment															

Veteran Condition 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% success 75% complete

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 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 and 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:

Copy of plan supplied to veteran: ☐ **CVC UP01** ☐ **CVC UP03** ☐

Care coordinator name: **CVC UP02** ☐ **CVC UP04** ☐

SYMPTOM ACTION PLAN

What is it? The Symptom Action Plan is designed to help you and your doctor and care coordinator to manage your conditions. The Symptom Action Plan identifies the action you should take when these signs appear. If the state of your conditions 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: DVA Card No:

Admissions during past 2 years: 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	**Contact details**
Doctor		
CVC Care Coordinator		
Hospital	**Emergency Department**	