

(Affix patient identification label here)

URN:

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

# End Stage Heart Failure Care Plan Checklist

## Care Planning Checklist

<b>Comprehensive patient health assessment</b>	<b>Patient identified issue/ concern</b>	<b>Referral to:</b>	
Patients may have many issues and concerns which will require referral to allied health and other team members (eg. social work, physio therapy, pharmacy, dietetics, speech therapy and occupational therapy)	Accommodation		
	Transport		
	Personal care		
	Respite care		
	Concern for carers		
	Relationships		
	Psychological distress		
	Spirituality and culture		
	Religious needs		
	Speech and hearing difficulties		
	Swallowing		
	Oral intake		
	Medication management		
	Mobility		
	Equipment needs		
<b>Personal/Carer issues</b>	Respite		
	Medication management		
<b>Psychosocial issues – Carer/Family</b>	Name of carer: _____ Relationship to patient? _____ Age of carer: _____ Contact Details: _____ Does the carer require on going support? <input type="checkbox"/> Yes <input type="checkbox"/> No What is the capacity of the carer to provide support? _____		
<b>Completed by</b> (print name):	<b>Designation:</b>	<b>Signature:</b>	<b>Date:</b>

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## End Stage Heart Failure Care Plan Checklist continued...

### Care Planning Checklist continued...

<b>Patient's choices</b>	<p><b>Does the patient have an Advance Health Directive (AHD)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>YES</b> Has the most recent AHD been sighted? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of most recent AHD: ____/____/____ Location: _____</p> <p>If <b>NO</b> Benefits of AHD explained to patient/patient's family Patient indicated they would like to create an AHD</p> <p><b>Enduring Power of Attorney (Health and Finance)</b></p> <p>a) Health: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be completed Name: _____</p> <p>b) Finance: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To be completed Name: _____</p> <p><b>Statutory Health Authority (name):</b> _____ (Person such as next of kin or unpaid carer who are capable of making health related decisions)</p> <p>Will <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Patient's preferred place of care: _____</p> <p>Patient's preferred place of death: _____</p>															
<b>Bereavement</b>	<p>Who is likely to be most affected by the death of the patient? _____</p> <p>Patient's wishes for action now: _____</p> <p>_____</p> <p>Patient's wishes for action at time of death: _____</p> <p>_____</p> <p>Need for ongoing support identified: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>															
<b>Primary Care Medical</b>	<p>Name of GP: _____ Phone: _____ Fax: _____</p> <p>Address: _____</p> <p>Who is providing after hours cover?</p> <p>Name: _____ Phone: _____ Fax: _____</p>															
<b>Primary Care Nursing</b>	<p>Referral to Community based Domiciliary agency required? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>YES</b> Known to agency? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of agency: _____ <input type="checkbox"/> Patient consent obtained</p> <p>Contact details: _____</p> <p>After hours support? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, type of support: <input type="checkbox"/> Telephone <input type="checkbox"/> After hours home visits <input type="checkbox"/> Other:</p>															
<b>Specialist Referrals</b>	<p><b>Palliative Care</b> Name of service: _____ Phone: _____ Fax: _____</p> <p><b>Other Medical Referrals</b></p> <table border="1"> <thead> <tr> <th>Name of specialist</th> <th>Speciality</th> <th>Contact details</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name of specialist	Speciality	Contact details												
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This protocol is intended as a guide only and does not replace clinical judgement