(Affix patient identification label here)

URN:

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

HEART online
Heart Education Assessment Rehabilitation Toolkit

End Stage Heart Failure Management Protocol

Care Planning Checklist

Comprehensive patient health assessment 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)	**Patient identified issue/ concern**	**Referral to:**
	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	
	Environment and safety	
	Financial	
Personal/Carer issues	Respite	
	Medication management	
Psychosocial issues – Carer/Family	Name of carer: _____ Relationship to patient? _____ Age of carer: _____ Contact Details: _____ Does the carer require on going support? ☐ Yes ☐ No What is the capacity of the carer to provide support? _____	

Completed by (print name):	**Designation:**	**Signature:**	**Date:**

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HEART online
Heart Education Assessment Rehabilitation Toolkit

End Stage Heart Failure Management Protocol continued...

Care Planning Checklist continued...

Patient's choices

Does the patient have an Advance Health Directive (AHD)? ☐ Yes ☐ No

If *YES* Has the most recent AHD been sighted? ☐ Yes ☐ No
Date of most recent AHD: ___/___/___ Location: _____

If *NO* Benefits of AHD explained to patient/patient's family
Patient indicated they would like to create an AHD

Enduring Power of Attorney (Health and Finance)

a) Health: ☐ Yes ☐ No ☐ To be completed Name: _____

b) Finance: ☐ Yes ☐ No ☐ To be completed Name: _____

Statutory Health Authority (name): _____

(Person such as next of kin or unpaid carer who are capable of making health related decisions)

Will ☐ Yes ☐ No ☐ Unknown

Patient's preferred place of care: _____

Patient's preferred place of death: _____

Bereavement

Who is likely to be most affected by the death of the patient? _____

Patient's wishes for action now: _____

Patient's wishes for action at time of death: _____

Need for ongoing support identified: ☐ Yes ☐ No

Primary Care Medical

Name of GP: _____ Phone: _____ Fax: _____

Address: _____

Who is providing after hours cover?

Name: _____ Phone: _____ Fax: _____

Primary Care Nursing

Referral to Community based Domiciliary agency required? ☐ Yes ☐ No

If *YES* Known to agency? ☐ Yes ☐ No

Name of agency: _____ ☐ Patient consent obtained

Contact details: _____

After hours support? ☐ Yes ☐ No

If yes, type of support: ☐ Telephone ☐ After hours home visits

☐ Other:

Specialist Referrals

Palliative Care

Name of service: _____ Phone: _____ Fax: _____

Other Medical Referrals

Name of specialist	Speciality	Contact details

Completed by (print name):	**Designation:**	**Signature:**	**Date:**

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