

# My Shared Care Plan

A Health Management Tool



Additional copies located on  
[www.patientpowered.org](http://www.patientpowered.org)

### What is “My Shared Care Plan”?

“My Shared Care Plan” is a self-management tool that can help you keep track of what is going on with your health. Having this information with you when you visit your doctor may help you become more of a partner in your care.

“My Shared Care Plan” has been tested with more than 40 patients across Whatcom County, WA who are living with diabetes and/or heart failure. We would like to hear what you think. Visit [www.PatientPowered.org](http://www.PatientPowered.org) to share your thoughts and to see what others are saying.

### How can I make the most of “My Shared Care Plan”?

Fill out all of the information that you know in “My Shared Care Plan”. If there are things you don’t know, ask for that information from your clinic at your next visit. Bring “My Shared Care Plan” with you to all of your health care appointments. Ask your care team members (doctors, nurses, therapists, pharmacists, etc.) to look at “My Shared Care Plan” for a current picture of your health and to help you keep the information accurate, up-to-date, and complete. You can also work together to define problems, set priorities, establish goals, create treatment plans, and solve problems.

### What is “Self-Management”?

Self-management means that you play a key role in managing your care. You are part of a team, along with your doctors, nurses, pharmacists and others, working together to manage your health. For more information on self-management, visit [www.PatientPowered.org](http://www.PatientPowered.org).

### What are “Advanced Directives”?

Advanced Directives state your preferences for end of life decisions. These include:

- **Healthcare Advance Directives (Living Will):** This is a legal form that does not require a lawyer. Your Living Will communicates your wishes about artificially prolonging your life if you are unable to make your wishes known.\*\*\* Living Will's are not recognized in the state of MI.\*\*
- **Physician Order for Life Sustaining Treatment (POLST):** This is a bright green form you and your physician must complete and sign together. These Physician’s orders state your preferences for end of life medical care.
- **Durable Power of Attorney for Health Care:** This is a legal form that does not require a lawyer. This form allows you to name a person as your health care agent – someone who can make decisions about your medical care if you are unable to make the decisions for yourself.

For more information on Advanced Directives, talk to your Doctor. You can also obtain forms and information from the Washington State Medical Association 1-800-552-0612.

### What are “Next Steps”?

“Next Steps” are small, short-term goals that move you in the direction of a positive lifestyle change. Share your next steps with your care team members so they can support you in reaching your goals.

### How can I get another copy of “My Shared Care Plan”?

You can find this file at [www.PatientPowered.org](http://www.PatientPowered.org).

You can also pick up a copy of “My Shared Care Plan” at

- LifeQuest - (360)738-6720  
3333 Squalicum Parkway Bellingham, WA 98225
- St. Joseph Hospital – Information Desk  
2901 Squalicum Parkway Bellingham, WA 98225.

<b>My name:</b>	<b>Birthdate:</b>	<b>Updated date:</b>
<b>Phone:</b> (days) (eves/wknds)	<b>Email address:</b>	
<b>Insurance Company:</b>		
<b>Emergency contact and phone:</b>		

<b>I want the person working with me to know...</b>		
<b>I have challenges with:</b> <input type="checkbox"/> Transportation <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> English as a second language (ESL) <input type="checkbox"/> Other Comments:		
<b>I have issues with Diet:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
<b>My Religion/Spirituality impacts my health care:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
<b>Advanced Directives</b>		
Healthcare Advance Directives	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
Physician Orders for Life Sustaining Treatment (POLST)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
Power of Attorney (Financial / Healthcare)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Comments:
<b>I live:</b> <input type="checkbox"/> alone <input type="checkbox"/> partner/spouse <input type="checkbox"/> Extended family <input type="checkbox"/> Other:		
<b>I learn best by:</b> <input type="checkbox"/> Reading <input type="checkbox"/> Being talked to <input type="checkbox"/> Being shown how <input type="checkbox"/> Listening to tapes <input type="checkbox"/> Seeing pictures or video		
<b>I have access to the Internet:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		

Next appointment	Name	Office Phone	On-Call Number	Role
				Primary Care Doctor

<b>I authorize that my personal health record to be shared with my care team listed above:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Others with whom I agree to view my plan include:</b>
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Medical Condition/Diagnosis		

Drug Allergies/Intolerances	Reaction	Date Occurred	Comments
Other Allergies:			

Over-the-counter Medications I take				
Name	Directions	Times Taken	Why I take this	Comments

Prescription Medications									
Date	Prescribed by	Drug Name	Directions	Why I take this	B 8-9	L 12-1	D 6-8	Bed 9-11	Comments
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Medications I have stopped taking									
Date I stopped taking it	Prescribed by	Drug Name	Directions	Why I took this	B 8-9	L 12-1	D 6-8	Bed 9-11	Why I stopped taking this
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**I am concerned about:**

- My ability to manage my chronic condition      My decreased energy level / Fatigue  
 Financial issues  
 Having access to healthcare  
 Emotional issues      Family issues      Spiritual support      Thinking or memory problems      End of life issues  
 Other:

**My Next Steps:**

**This section to be completed by you in partnership with your care team. Steps may include concerns about medical condition, problems, barriers or goals and are followed by action, solutions, observations, the current status of the step, etc.**

Date	Concerns / Problems / Actions / Comments / Status	By Whom

**Health Logs:**

**(i.e., blood sugar test results, daily weight, lab results, exercise schedule)**
