HOME AND COMMUNITY CARE SUPPORT SERVICES
North East

WOUND SELF MANAGEMENT PROGRAM

YOUR PASSPORT TO HEALTH

Your Health Passport is for you and your family and/or caregiver. It contains information that is important to you, your condition and treatments as you begin managing your wound. Inside you will find forms and tables that will become a daily log as you move through caring for your wound. Make sure you bring this passport with you to all your medical appointments/procedures.

310-2222 or or 1-888-533-2222

Ontario

HELPING YOU HEAL

You have been assessed as eligible for acceptance into the Home and Community Care Support Services North East client self-management program – *Helping You Heal*.

The aim of this program is to improve the health and quality of life for people living with wounds.

Your care will be managed by YOU with the help of our care team.

ABOUT YOUR HEALTH PASSPORT

The central goal of the *Helping You Heal* Initiative is to help you live as actively, healthy and independently as possible within in your community.

This passport has been created to help you keep track of medical appointments, contact information, medication, goals, advice, and questions.

You will use this passport to keep clear, up-to-date records of treatment and support available throughout managing your wound.

Keep updating your passport as you continue to make progress in your recovery by setting yourself new goals to work towards, and recording all events throughout your care.

Your care team will also support you in achieving your goals with advice, information, and guidance.

Be sure to take your passport to clinic appointments and to keep the information up to date.

INFORMATION

As part of the *Helping You Heal* initiative you have already met your visiting nurse. Your educational booklet will explain when to call your nurse. Your nurse will write their contact information below:

Name _____

Phone Number _____

E-Mail _____

Alternate Ph. Number _____

CONTACT INFORMATION

MY PERSONAL DETAILS

NAME	
ADDRESS	
DATE OF BIRTH	
LANGUAGE(S) SPOKEN	
TELEPHONE NUMBER	
E-MAIL	
HEALTH CARD NUMBER	
HOSPITAL	

NEXT OF KIN PERSONAL DETAILS

NAME ADDRESS	
TELEPHONE NUMBER	
E-MAIL	
ALTERNATE CONTACT NAME	
ADDRESS	
TELEPHONE NUMBER	

MY HEALTH CARE TEAM

MY FAMILY DOCTOR/NURSE PRACTITIONER

NAME	
ADDRESS	
PHONE NUMBER	

MY CARE COORDINATOR

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

MY PHYSIOTHERAPIST

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

MY OCCUPATIONAL THERAPIST

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

MY SPEECH AND LANGUAGE THERAPIST

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

MY DIETITIAN

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

OTHER SPECIALIST (STATE: CARDIOLOGIST-HEART, NEUROLOGIST-BRAIN)

NAME	
ADDRESS/HOSPITAL	
PHONE	

OTHER SPECIALIST (STATE: CARDIOLOGIST-HEART, NEUROLOGIST-BRAIN)

NAME	
ADDRESS/HOSPITAL	
PHONE	

OTHER SPECIALIST (STATE: CARDIOLOGIST-HEART, NEUROLOGIST-BRAIN)

NAME	
ADDRESS/HOSPITAL	
PHONE	

MY SOCIAL WORKER

NAME	
ADDRESS	
PHONE NUMBER	

MY PHARMACIST

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

MY NURSING AGENCY

NAME	
ADDRESS	
PHONE NUMBER	

OTHER

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

OTHER

NAME	
ADDRESS/HOSPITAL	
PHONE NUMBER	

OTHER

NAME	
ADDRESS/HOSPITAL	
PHONE	

WOUND INFORMATION

Hospital admission information			
I was first admitted to (hospital):			
Date:			
Under the care of:			
I have been diagnosed as having a (List wound type)		Please check	Date

Other medical problems:

□ High blood pressure □ Diabetes on: □ Insulin □ Pills

□ Heart Attack □ Heart Failure □ Atrial Fibrillation

□ Heart Valve surgery □ Coronary Bypass Surgery

□ Coronary Angioplasty □ Pacemaker □ Defibrillator

□ Lung Disease Type: _____

□ Cancer: Type: _____

□ Kidney Disease □ Liver Disease □ Depression

□ Thyroid Disease □ Seizures Other _____

NOTES

MY MEDICATIONS

I am allergic to the following medications:

_____
_____
_____

List all your current medication, vitamins & supplements:

Date started MD/NP	**Medication (name and purpose)**	**Dosage + frequency**	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**	**Other**
1/1/2011 *Dr. X*	*e.g. Aspirin for blood thinning*	*81 mg once a day*					*10AM*

MY APPOINTMENTS

While managing your wound, you may need to attend medical appointments. You will need to see your family doctor, nursing clinic & other members of your health care team. It is important that you attend these appointments as the team will help your recovery. This section allows you to keep all your appointments in one place. This will also allow your healthcare team to know who you are seeing & when.

Date	Time	Appt. With	Location	Comments

ROUTINE OR OTHER TESTS

You may also need to undergo routine or other diagnostic tests. It is important to write the results of your test so that other members of the team are aware of what has taken place. You may need to ask your specialist/health care team member to write in the results for you.

Date	Time	Test	Location	Results

HOSPITAL ADMISSION/ URGENT CARE/EMERGENCY ROOM VISITS

Date	Reason

PERSONAL GOALS

It is important to have goals for your healing. Please answer the following:

What change would you like to see happen TODAY?

What change would you like to have happen NEXT WEEK?

What change would you like to have happen NEXT MONTH?

What steps will you take to achieve these goals?

What support and resources will you need?

What is your plan for overcoming any challenges?

PLEASE CIRCLE THE FOLLOWING, INDICATING THE IMPORTANCE TO YOU

	Not Applicable	Not Important	Important		Very Important	
Being able to drive myself around	N/A	1	2	3	4	5
Healing my wound	N/A	1	2	3	4	5
Activities of daily living (church, shopping, enjoying friends/family)	N/A	1	2	3	4	5
Playing with my kids/grandkids	N/A	1	2	3	4	5
Staying out of the hospital	N/A	1	2	3	4	5
Maintaining an active sex life	N/A	1	2	3	4	5
Enjoying a balanced diet	N/A	1	2	3	4	5
Exercising	N/A	1	2	3	4	5
Being able to work	N/A	1	2	3	4	5
Not being embarrassed of my wound	N/A	1	2	3	4	5

PERSONAL ACTION PLAN

Now that you have identified areas in your life that are most important to you, please answer the following:

What are the most important areas of your life?

What areas of your life does your wound impact the most and why?

What changes may make this area of your life better?

What do you find most unpleasant about your wound?

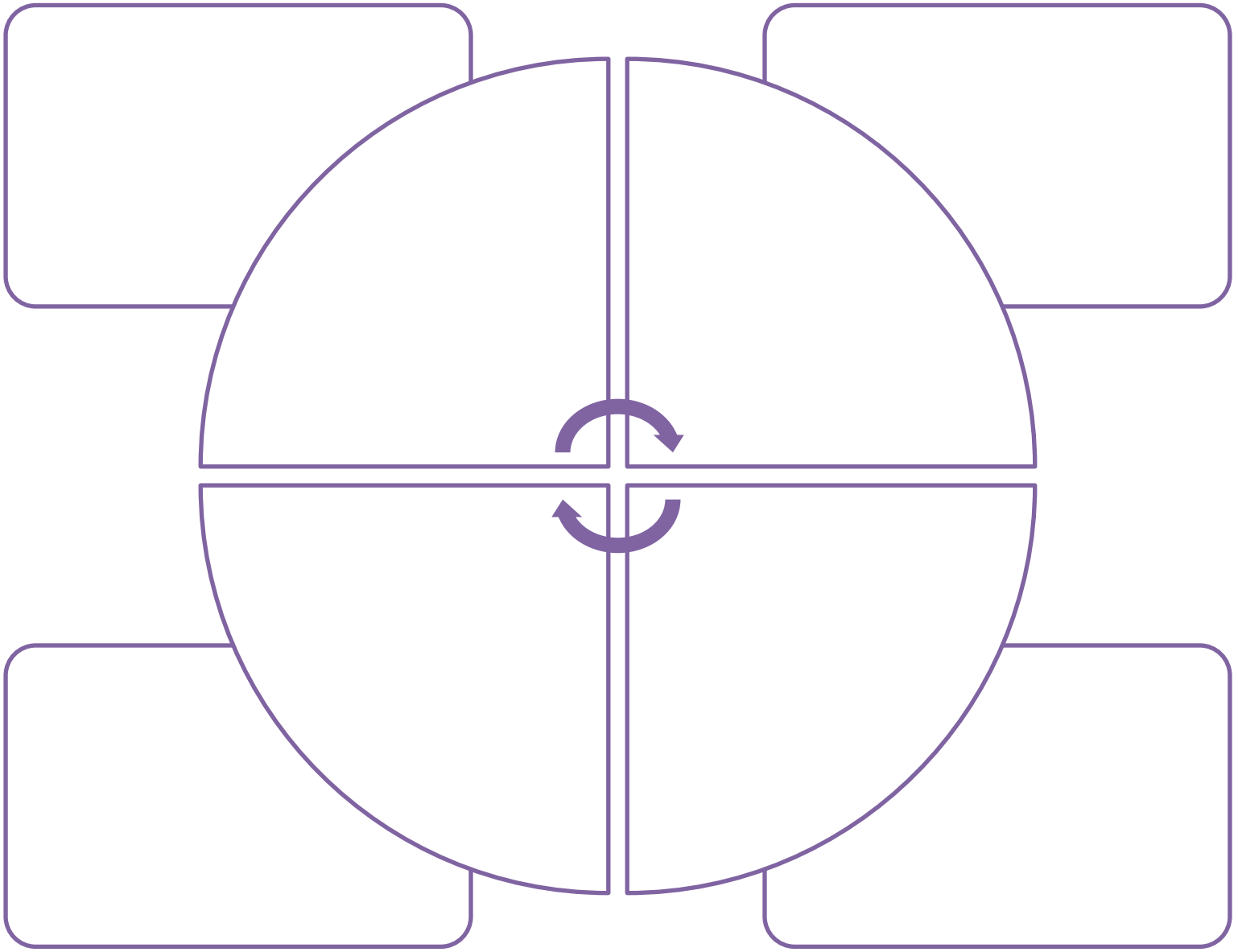
What changes may make this unpleasantness better?

What areas of care are you excited to do independently?

PERSONAL ACTION PLAN / GOALS

Your nurse will help you summarize your goals and the action items that you worked on in the previous pages.

Please put your goals in the inner circles And your action items in the outside boxes



CONTACT US

Call us toll-free at 310-2222, no area code required.

healthcareathome.ca/northeast |
northeasthealthline.ca

Home and Community Care Support Services North East has many community offices to serve you, including:

KIRKLAND LAKE

53 Government Road West
Kirkland Lake ON P2N 2E5
Telephone: 705-567-2222
Toll free: 1-888-602-2222

NORTH BAY

1164 Devonshire Ave.
North Bay ON P1B 6X7
Telephone: 705-476-2222
Toll free: 1-888-533-2222

PARRY SOUND

6 Albert Street
Parry Sound ON P2A 3A4
Toll free: 1-800-440-6762

SAULT STE. MARIE

390 Bay Street, Suite 103
Sault Ste. Marie ON P6A 1X2
Telephone: 705-949-1650
Toll free: 1-800-668-7705

SUDBURY

40 Elm St, Suite 41-C
Sudbury ON P3C 1S8
Telephone: 705-522-3461
Toll free: 1-800-461-2919
TTY: 711 (ask operator for 1-888-533-2222)

TIMMINS

330 Second Avenue, Suite 101
Timmins ON P4N 8A4
Telephone: 705-267-7766
Toll free: 1-888-668-2222