**COORDINATE MY CARE (CMC)**

**CARE PLAN**

This CMC plan is to be completed by a trained Healthcare Professional with the patient, in the presence of at least one family member/carer. If the patient lacks the capacity to make these decisions, it will be filled out by the Healthcare Professional and family members, in the best interest of the patient

# patient information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Name |  | | | | | |
| Preferred Name |  | | | | | |
| NHS number |  | | | | | |
| Address |  | | | | | |
| Home Phone |  | | | | | |
| Mobile Phone |  | | | | | |
| Date of Birth |  | | | | | | |
| Gender | MALE |  | FEMALE |  | PREFER NOT TO SAY |  | |
| Marital Status |  | | | | | | |
| Religion |  | | | | | | |
| Ethnicity |  | | | | | | |
| Language |  | | | | | | |
| CMC number |  | | | | | | |

## Significant Medical Diagnosis

|  |
| --- |
|  |

## Patient aware of diagnosis? (Tick the appropriate box and include any additional details below)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Additional details

|  |
| --- |
|  |

## Family/Carer(s) aware of the diagnosis? (Tick the appropriate box and include any additional details below)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Additional details

|  |
| --- |
|  |

## Other Significant Past Medical History and Disability

|  |
| --- |
|  |

## WHO Performance Status (Tick the appropriate box)

|  |  |
| --- | --- |
|  | 0 – Able to carry out all normal activity without restriction |
|  | 1 – Restricted in strenuous activity but ambulatory and able to carry out light work |
|  | 2 – Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours |
|  | 3 – Symptomatic and in a chair or in a bed for greater than 50% of the day but not bedridden |
|  | 4 – Completely disabled cannot carry out any self-care; totally confined to bed or chair |

# PATIENT’S WISHES

## Patient’s Preferred Place of Care?

|  |
| --- |
|  |

## Patient’s First Preferred Place of Death?

|  |
| --- |
|  |

## Patient’s Second Preferred Place of Death?

|  |
| --- |
|  |

## Patient’s wishes

|  |
| --- |
|  |

## Family awareness

|  |
| --- |
|  |
|  |

## Organ Donor? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Organ Donor Details

|  |
| --- |
|  |

## Cultural/Religious Needs

|  |
| --- |
|  |

# CARDIOPULMONARY RESUSCITATION (CPR) DICISSION

|  |
| --- |
| **Date of Discussion** |
|  |

## Discussion with Patient? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Summary of Patient Discussion

|  |
| --- |
|  |

|  |
| --- |
| Date of Discussion |
|  |

## Discussion with Family? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Summary of Family Discussion

|  |
| --- |
|  |

|  |
| --- |
| Date of CPR Decision |
|  |

## Should CPR Commence? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Is there a Welfare Attorney? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Location of DNA CPR Form?

|  |
| --- |
|  |

## Has the DNA CPR Form been attached? (Tick the appropriate box and ensure the form is attached)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

# Clinician and care Team information

## Clinician Name

|  |
| --- |
|  |

## Position

|  |
| --- |
|  |

## Other Team Members

|  |
| --- |
|  |

## Date & Time

|  |
| --- |
|  |

## Does the patient have the mental capacity to make this decision? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Is the clinician aware of a valid advance decision refusing CPR? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## If the CPR is not appropriate, why?

|  |
| --- |
|  |

## Next Date to Review CPR Decision

|  |
| --- |
|  |

## Emergency Treatment Plan

|  |
| --- |
|  |

## Medication

|  |
| --- |
|  |

## Allergies

|  |
| --- |
|  |

# HEALTH & SOCIAL CARE CONTACTS

## Full Name

|  |
| --- |
|  |

## Role

|  |
| --- |
|  |

## Contact Number

|  |
| --- |
|  |

## Other Contact Information

|  |
| --- |
|  |

## Full Name

|  |
| --- |
|  |

## Role

|  |
| --- |
|  |

## Contact Number

|  |
| --- |
|  |

## Other Contact Information

|  |
| --- |
|  |

# PERSONAL CONTACTS

## Full Name

|  |
| --- |
|  |

## Relationship to patient

|  |
| --- |
|  |

## Main Carer? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES |  | NO |  |

## Contact Number

|  |
| --- |
|  |

## Other Contact Information

|  |
| --- |
|  |

# HEALTH & WELFARE LAST POWER OF ATTORNEY(S)

## Full Name

|  |
| --- |
|  |

## Contact Number

|  |
| --- |
|  |

## Other Contact Information

|  |
| --- |
|  |

# Social Situation

## NHS Funded Continuing Care? (Tick the appropriate box)

|  |  |  |  |
| --- | --- | --- | --- |
| YES (social service funded) |  | NO (social service NOT funded) |  |

## Help with Care

|  |
| --- |
|  |

## Equipment

|  |
| --- |
|  |

## Family Support

|  |
| --- |
|  |