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Version 2024

Care Passport

For the coordinated care of people with multiple chronic health conditions

This document is to be treated confidentially.

With the help of this care passport, your care will be even better tailored to your personal needs and expectations. Additionally, this passport allows for an improved exchange of your information between various healthcare professionals in charge of your care.

These professionals are obliged to treat all your personal data confidentially and may not disclose them without your consent. QualiCCare has at no time access to your personal data.

Pages 2 – 11 are to be completed by the patient alone or with the assistance of a caregiver. During your next appointment at your general practitioners office, you can ask any questions you may have about the care passport.

Personal details

Name / First name
Street/No.
Zip code / City
Phone
E-Mail
Date of birth
Name of health insurance
Insurance model
SSN no.
Signature*

Reference persons and/or Representatives in medical matters

(who are not members of my treatment team on page 4)

Can be contacted if necessary and may be informed about the contents of this care passport. (e.g. partner, son/daughter, relative, neighbour)

Name / First name	
Phone / E-Mail	
Relationship to patient	
Name / First name	
Name / First name Phone / E-Mail	

10		4/	
(Continuation: re	ejerence persons an	d/or representatives in	meaicai matters.)

Name / First name	
Phone / E-Mail	
Relationship to patient	
Name / First name	
Phone / E-Mail	
Relationship to patient	
Coordinator (en	ter manually or stamp possible)
the exchange of info	, APN) currently coordinates my care and ensures rmation within the healthcare team and with
the reference persor	t be notified in case of acute events.
The coordinator mus	t be notined in case of acute events.
Name / First name	
Profession / Specialty	
Phone / E-Mail	
Address / Stamp	
Signature*	

Or:

I coordinate my care myself.

^{*} With my signature, I confirm the information I have provided in this passport and agree to keep it up to date – as far as possible – and to refer to the passport during the consultation.

Healthcare Team (can be entered manually or stamped)

The following people are currently taking care of me and may share information from this care passport with each other.

Profession / Specialty Phone / E-Mail Signature* professional Name / First name Profession / Specialty
Specialty Phone/E-Mail Signature* professional Name/First name Profession/
Phone/E-Mail Signature* professional Name/First name Profession/
Name / First name Profession /
Profession/
Phone / E-Mail
Signature* professional
Name / First name
Profession / Specialty
Phone/E-Mail
Signature* professional
Name / First name
Profession / Specialty
Phone / E-Mail
Signature* professional
Name / First name
Profession / Specialty
Phone / E-Mail
Signature* professional

At the next appointment, please request the signature of the respective healthcare professionals. (e.g. general practitioner, pharmacist, specialist, psychologist, physiotherapist, social worker, home care)

Name / First name	
Profession / Specialty	
Phone/E-Mail	
Signature* professional	
Name / First name	
Profession / Specialty	
Phone/E-Mail	
Signature* professional	
Name / First name	
Profession / Specialty	
Phone / E-Mail	
Signature* professional	
Name / First name	
Profession / Specialty	
Phone/E-Mail	
Signature* professional	
Name / First name	
Profession / Specialty	
Phone / E-Mail	
Signature* professional	

^{*} With this signature, I confirm the information I have provided in this passport and agree to keep it up to date – as far as possible – and to refer to the passport during the consultation.

Current health problems

I am currently affected by the following physical, psychological and/or social issues:

(e.g., pain, fatigue, anxiety, sleep disorders, forgetfulness, loneliness, housing situation, work situation, relationship problems, financial problems, etc.)

Also mention problems that are more difficult to discuss (e.g. incontinence, appetite and eating disorders, sexuality and impotence, balance and falls issues, compliance with therapy measures, etc.)

Date	Health problems

Current resources (sources of energy)

Here are aspects of my life that contribute to my well-being and health: (e.g., circle of friends, family, interests and hobbies/leisure activities, etc.).					

Goals

1. What three important goals do you have for the next 12 months?

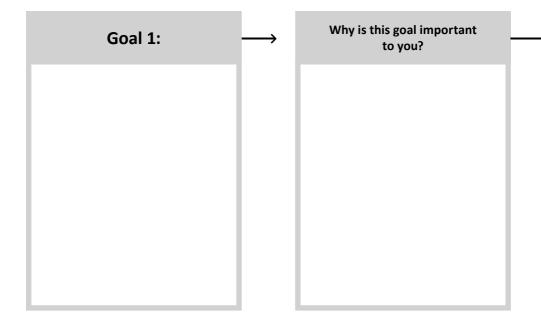
Think of the things you want to do in your personal, professional and social life – things you need to do, want to do or enjoy doing.

Then list the goals in order of priority – starting with 1 for the goal that matters to you most and that you would like to focus on first.

2. Why are these goals important to you?

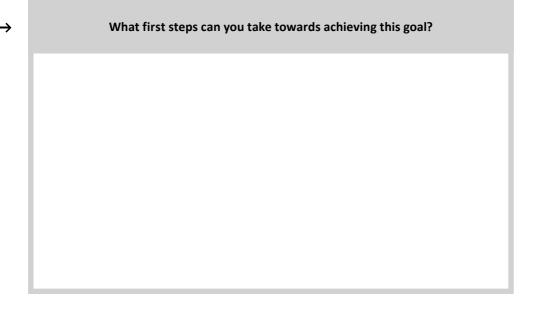
We now ask you to think about why they are important to you.

You can use the template below (also on the next pages). We ask you to do this exercise with the three listed goals.



3. What are the first steps you would like to take to achieve your goal(s)?

Having identified your most important goals, we ask you to think about the first steps you would like to take towards achieving each respective goal.



Goals

Goal 2:	\longrightarrow	Why is this goal important to you?	_
Goal 3:	\longrightarrow	Why is this goal important to you?	_
Goal 3:	→	Why is this goal important to you?	
Goal 3:	>	Why is this goal important to you?	
Goal 3:	>	Why is this goal important to you?	
Goal 3:	>	Why is this goal important to you?	
Goal 3:	>	Why is this goal important to you?	

>	What first steps can you take towards achieving this goal?
>	What first steps can you take towards achieving this goal?

List of diagnoses This list can also be printed and attached to the care passport.

Current list of diagnoses including psychiatric diagnoses and addictions, nursing diagnoses and sensory impairments	Year of first diagnosis

Notable operations / interventions and / or allergies / intolerances	Date	
		s list
		Space to attach diagnoses list
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Care plan

This overview lists the *mutually agreed upon* objectives and the measures to be taken to achieve them. The goals should be specific, measurable, and time-bound.

Goal / Indicator	Measure

The objectives and measures are to be reviewed during each consultation and adjusted if necessary.

Agreed on, with	Deadline	Reviewed on, by

Care plan

This overview lists the *mutually agreed upon* objectives and the measures to be taken to achieve them. The goals should be specific, measurable, and time-bound.

Goal / Indicator	Measure

The objectives and measures are to be reviewed during each consultation and adjusted if necessary.

Agreed on, with	Deadline	Reviewed on, by

Medication-related problems

A comprehensive medication check is performed during the patient's visit. The healthcare professional documents any pharmaceutical recommendations in the care passport.

Date / Signature responsible professional	Medication	Medication-related problem

Pharmaceutical recommendation and / or comments

Medication-related problems

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Date / Signature responsible professional	Medication	Medication-related problem

Dharmacautical recommendation and I are comments
Pharmaceutical recommendation and / or comments

Follow-up controls These parameters can also be printed and attached to the care passport.

Healthcare professionals can define and document necessary clinical parameters which should be measured regularly, such as blood pressure (mmHg), blood sugar (HbA1c), blood fat (LDL), or body weight (BMI), etc.

Relevant clinical parameters	Value / Date / Professional	Value / Date / Professional

Please enter the date of the measurement, the measured value and the responsible professional

| Value / Date /
Professional |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
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| Value / Date /
Professional |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
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Next appointments

The next appointments are planned as follows:

Date/Time	With (name / healthcare professional)

Data / Tima	With (name / healthcare professional)
Date/Time	With (name / healthcare professional)
·	

Important documents I have the following documents (please check as appropriate and/or add further documents): ☐ Medication plan ☐ Vaccination card ☐ Diabetes passport ☐ Blood pressure passport ☐ Anticoalgulation card ☐ Allergy passport

☐ Advance directives placed with:

C	omments		

Comments	

