**Preparing for care planning**

**Full name: DOB: NHS No:**

Here are your test results along with some things to think about before your care planning appointment. Please have this available at your appointment.

At your appointment we will talk about:

* what is important to you
* any questions you might have
* things you can do to live well and stay well

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| **What are the most important things to you at the moment?** |
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| **These are things that people sometimes want to talk about.**  |
| Sleep | Managing my symptoms | My future health |
| Medication | Feeling down or stressed | Feeling lonely |
| Memory | Eating the right amount  | Keeping active and getting around |
| Food choices | Giving up smoking | Relationships/sex life |
| Pregnancy and contraception | Coping with my day to day life | Work/benefits/money |
| Driving/travel | Alcohol  | Pain/discomfort |

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| **What else would you like to discuss?** |
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| **GENERAL HEALTH AND WELLBEING ISSUES** |

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| **WEIGHT** |
| Being overweight can make your condition harder to control. It can increase your chances of health problems. |
| **CURRENT** | **PREVIOUS** |
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| **BODY MASS INDEX (BMI)** |
| Your BMI tells you if you are a healthy or unhealthy weight for your height. | **Low risk** | **More risk** | **Higher risk** |
| 20 to 25 | 25 to 30 | Above 30 |
| **CURRENT** | **PREVIOUS** |
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| **SMOKING**  |
| Stopping smoking is one of the best things you can do to stay healthy. | **Low risk** | **More risk** | **Higher risk** |
| Non smoker | Ex or passive | Tobacco user |
| **Current smoking status** |  |

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| **MOOD**  |
| How you feel can make a big difference to your health – have a think about how your long term condition has affected your mood recently.* During the last month, have you been bothered by feeling down, depressed, or hopeless?
* During the last month have you had little interest or pleasure in doing things?
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| **DIABETES TESTS AND CHECKS** |
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| **HbA1c** |
| HbA1c is measure of blood glucose control over the past 8-10 weeks. Levels between 48 and 59 have the lowest risk of future health problems. | **Low risk** | **More risk** | **Higher risk** |
| Less than 59 | 59 to 69 | Above 69 |
| **CURRENT** | **PREVIOUS** |
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| **BLOOD PRESSURE** |
| Keeping your blood pressure below 140/90 reduces your risk of health problems (a level below 130/80 is used if you have kidney disease). | **Low risk** | **More risk** | **Higher risk** |
| Less than 140/90 | 140/90 to 160/90 | 160/90 or above |
| **CURRENT** | **PREVIOUS** |
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| **CHOLESTEROL AND BLOOD FATS**  |
| Non-HDL cholesterol is the bad type of fat in your blood and the ideal level is below 2.5 mmol/L. | **Low risk** | **More risk** | **Higher risk** |
| Less than 2.5 | 2.5 to 4.0 | Above 4 |
| **CURRENT** | **PREVIOUS** |
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| **KIDNEY TESTS: Your kidneys are tested by looking at two tests:** |
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| **EARLY MORNING URINE TEST (ACR)** |
| An early morning urine test is Albumin/Creatinine Ratio (ACR). ACR results are better if under 3.0. | **Low risk** | **More risk** | **Higher risk** |
| Less than 3.0 | 3.0 to 5.0 | Above 5.0 |
| **CURRENT** | **PREVIOUS** |
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| **BLOOD TEST (eGFR)** |
| A blood test (eGFR) checks how well your kidneys are working. Ideally your eGFR should be above 60 and be stable. | **Low risk** | **More risk** | **Higher risk** |
| Above 60 | 45 to 60 | Below 45 |
| **CURRENT** | **PREVIOUS** |
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| **EYES** |
| Your eye check looks for any changes to the tiny blood vessels at the back of your eye. | **Last screening** |
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| **FEET** |
| Your yearly foot check looks for problems with blood flow (circulation) and the feeling (nerves) in your feet. | **Last screening** |
| **Left foot** | **Right foot** |
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**Your care planning summary**

This will be used to summarise the conversations you have at your care planning appointment and the plan you agree.

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| **Your care planning appointment was with:** | **Date:** |
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| **Summary of the conversation** |
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| **Goal setting** |  | **Action planning** |
| **What do you want to work on?** |  | **What exactly are you going to do?** |
| **What do you want to achieve?** |  | **What might stop you and what can you do about it?** |
| **How important is it to you?** |  | **How confident do you feel?** |
| *Not important* | 1 2 3 4 5 6 7 8 9 10 | *Very important* |  | *Not confident* | 1 2 3 4 5 6 7 8 9 10 | *Very confident* |
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| **Follow up/review of goal/action plan:** |
| **When:** | **Where:** |