PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

RISK ASSESSMENT, GOALS, AND ACTION PLAN

DATE OF SERVICE			
Initial Visit / /	1st Follow-Up / /	2nd Follow-Up / /	3rd Follow-Up / /

PATIENT INFORMATION		
Last Name		First Name
Gender	Date of Birth / /	GSC ID #
Home Phone ( )		Cell Phone ( )

PHYSICIAN INFORMATION		
Last Name		First Name
Lic. #		
Office Phone ( )		Office Fax ( )
Address		Unit #
City	Province	Postal Code

MEDICATION HISTORY

☐ Complete medication assessment (Refer to *Medication Assessment* form); **or**
☐ Provincial medication review completed; **and**
☐ Review strategies to improve medication adherence (See Appendix A, Section I)

ADHERENCE ASSESSMENT (Based on MMAS-4, see Appendix A, Section I)

1. Do you sometimes forget to take your medications?	☐ Yes ☐ No
2. Over the past two weeks, were there any days when you did not take your medications for other reasons?	☐ Yes ☐ No
3. Have you ever stopped taking your medication without telling your doctor because you felt worse?	☐ Yes ☐ No
4. When you feel like your symptoms are under control, do you sometimes stop taking your medications?	☐ Yes ☐ No

Adherence Score	Initial / 4	3rd F/U / 4

BLOOD PRESSURE ASSESSMENT (See Appendix A, Section II)

Establish BP Target:

☐ ≤120 SBP mmHg (HIGH RISK) ☐ < 130/80 mmHg (DM) ☐ < 140/90 mmHg (ALL OTHERS/CKD)

☐ Review BP monitoring tips (if required)

Average HOME Blood Pressure Measurements

Initial Visit	1st Follow-Up	2nd Follow-Up	3rd Follow-Up
☐ Not available	☐ Not available	☐ Not available	☐ Not available
____ / ____ mmHg	____ / ____ mmHg	____ / ____ mmHg	____ / ____ mmHg

PHARMACY Blood Pressure Measurement

Initial Visit	1st Follow-Up	2nd Follow-Up	3rd Follow-Up
____ / ____ mmHg	____ / ____ mmHg	____ / ____ mmHg	____ / ____ mmHg
____ bpm	____ bpm	____ bpm	____ bpm

CHOLESTEROL ASSESSMENT (See Appendix A, Section III)

☐ Establish LDL Target: _____ mmol/L

Lipid Measurements

		☐ Reassessment (if required)
Date (dd/mm/yy)	_____	_____
Total cholesterol	_____ mmol/L	_____ mmol/L
Low-density lipoprotein	_____ mmol/L	_____ mmol/L
High-density lipoprotein	_____ mmol/L	_____ mmol/L
Non-HDL	_____ mmol/L	_____ mmol/L
Triglycerides	_____ mmol/L	_____ mmol/L

SMOKING HISTORY (See Appendix A, Section IV)

Document smoking status: ☐ Non-smoker ☐ Smoker ☐ Former smoker

☐ Document tobacco use: _____ cigarettes / pack per day for _____ years

☐ Ask: "Have you considered quitting?"

- ☐ Yes (advise patient of smoking cessation services available)
- ☐ No (discuss benefits of quitting)

LIFESTYLE INFORMATION (See Appendix A, Section V)

Height _____ Weight _____ Waist Circumference _____ BMI _____

Occupation _____

Physical Activity	Target Met	
Daily activity level: ☐ Sedentary ☐ Moderate ☐ Active	☐ Yes	☐ No
Active exercise: _____ days/week, _____ min/day	☐ Yes	☐ No
Intensity of exercise: ☐ Moderate ☐ Vigorous	☐ Yes	☐ No

Diet	Target Met	
Alcohol: _____ drinks per week	☐ Yes	☐ No
Caffeine: _____ cups per day	☐ Yes	☐ No
Sodium intake: ☐ Adequate (1200-1500mg/day) ☐ High (>2300mg/day)	☐ Yes	☐ No
Fruits and vegetables: ____ servings/day	☐ Yes	☐ No
Grain products: ____ servings/day	☐ Yes	☐ No
Milk and alternatives: ____ servings/day	☐ Yes	☐ No
Meat and alternatives: ____ servings/day	☐ Yes	☐ No
Fats and oils ____ servings/day	☐ Yes	☐ No

RISK ASSESSMENT (See Appendix A, Section VI)

- ☐ Review impact of cardiovascular disease
- ☐ Review non-modifiable risk factors
- ☐ Review modifiable risk factors

Cardiovascular Risk

Risk Profile:

10-year cardiovascular risk _____

To assess cardiovascular risk visit http://cvdrisk.nhlbi.nih.gov/

OR

Cardiovascular age _____

To assess cardiovascular age visit myhealthcheckup.ca

PATIENT-IDENTIFIED GOALS

During each visit ask: "What are the two most important areas for you to make a positive change?"

- ☐ Adhere to medication therapy
- ☐ Achieve a healthy weight
- ☐ Reduce stress
- ☐ Lower blood pressure
- ☐ Increase physical activity
- ☐ Quit smoking
- ☐ Lower cholesterol levels
- ☐ Adopt healthy eating habits
- ☐ Other

PHARMACIST NOTES

PHARMACIST HEALTH COACHING – CARDIOVASCULAR PROGRAM

RISK ASSESSMENT, GOALS, AND ACTION PLAN

SMART GOALS ARE SPECIFIC, MEASURABLE, ATTAINABLE, REALISTIC, TIMELY

INITIAL VISIT

Pharmacist Name: _____ Pharmacist Signature: _____ Date: / /

1ST FOLLOW-UP

Pharmacist Name: _____ Pharmacist Signature: _____ Date: / /

2ND FOLLOW-UP

Pharmacist Name: _____ Pharmacist Signature: _____ Date: / /

3RD FOLLOW-UP

Pharmacist Name: _____ Pharmacist Signature: _____ Date: / /

Provide patient with a copy of documentation.

PHARMACIST AGREEMENT

I agree to comply with all conditions laid out in the Personal Information Protection and Electronic Documents Act (PIPEDA), or other provincial privacy legislation requirements. I agree to comply with all conditions regarding privacy laid out in the Green Shield Canada Pharmacist Health Coaching training documents.

_____ Date: / /

Signature of Pharmacist

PATIENT AGREEMENT

By signing below, I agree to participate in the GSC Pharmacist Health Coaching Program. I understand that personal information collected will be used for the delivery of this coaching program. I understand that GSC may access this information for the purposes of audit or for the purposes of research. I understand that personal information collected will not be used for any other purpose by GSC or its agents. I understand that if I am not the plan member, the information contained on the form may be seen by the cardholder/plan member.

_____ Date: / /

Signature of Patient