NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MY CARE AND COMMUNICATION PLAN (TOP 5)

My preferred name is:
_____

T alk with Person/ Carer/ Family
O btain Information to
P ersonalise Care -
5 Strategies are recorded below (use patient's own words)

The most important things you need to know about me AND how to best support me:

1.

2.

3.

4.

5.

Guide for TOP 5 Strategies: Identify or negotiate with the person, support person or carer, the most important strategies applicable to the setting where the person is being (or will be) cared for. These questions may assist to personalise care:

- Are there things/situations that may cause distress? *(colours, topics, staff gender, visitors)*
- If unsettled, what may help settle or calm this person? *(music, relocation, reading, lighting, a cup of tea)*
- Any routines that help keep the person reassured? *(bedtime, meals, personal care, taking medication)*
- Any repetitive questions/ recurring issues that need specific answers? *What is the preferred answer?*
- Is there somebody that might be called out for? *(a person or a pet)*
- Any signs or triggers that indicate a need or a want? *(fidgeting sometimes indicates a need for the toilet)*

Completed by *(name)*: ..... Signature: ..... Print & Sign ..... Date: ...../...../.....

Relationship *(Person, Carer, Other)*: .....

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This form is to be completed for persons with cognitive impairment, (including people with delirium, dementia and intellectual disability), communication challenges or any other person for whom this information is helpful to support care. The form is to be completed by the person, their carer or support person.

Things you need to know about me: (☑tick the things about you)

You can add more detail in the Top 5 section on the front page.

Allergies or adverse reactions	☐	**I have an implanted device**	☐
I am at risk of aspiration or choking	☐	**I have a modified diet** e.g. thickened fluids or PEG	☐
I am at risk of falls	☐	**I need support for mobility**	☐
I need help to communicate	☐	**I need:** ☐ **interpreter** ☐ **AHLO** **Language:**	
I have sensory support needs	☐	**Other critical information:**	

My cultural background and/or spiritual beliefs are:

My best contacts (family, carers, support workers, guardian):

Name	Relationship to me	Phone number

My Health Care Team	Clinic/Organisation	Phone number
My GP:		
I have a My Health Record (tick)	☐ Yes ☐ No	
My Medicare Number		

My medications: Webster pack *(tick)* ☐ Yes ☐ No

Medication name	Dose	How often	How taken (i.e. tablet, liquid)

(Attach a separate sheet if necessary.)

Completed by: ……

(Print Name & Designation)

Print & Sign

Signature: …… Date: …… / …… / ……

Acknowledgements: Central Coast LHD for the original creation of the TOP 5 process, tools and resources.

NO WRITING