My Support plan – Template

A list of the things that determine the care I need

Name:	DOB:
Address:	Home phone: Mobile: Work: Email:
Living arrangements: (who do you live with?)	
Living environment: (e.g. unmodified or modified home/unit for my needs, supported accommodation)	
Carer Name: (if applicable)	
Address:	Home phone: Mobile: Work: Email:
Diagnosis:	Date of Diagnosis:
Medical History:	
GP Name:	
Address:	Work: Email:
What is important to you?	What are your goals for the next 12 months?

My regular routine and activities in a typical week – Use this table to help you identify all the things you do each day

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6.00-7.00 am							
7.00-8.00 am							
8.00-9.00 am							
9.00-10.00 am							
10.00-11.00 am							
11.00-12.00							
12.00 – 1.00 pm							
1.00-2.00 pm							
2.00-3.00pm							
3.00-4.00 pm							
4.00-5.00 pm							
5.00-6.00 pm							
6.00-7.00 pm							
7.00-8.00 pm							
8.00-9.00 pm							
9.00-10.00 pm							
10.00 pm +							

Functional requirements

Activity	Tick one	Domestic and personal care	Provide details of the aids and assistance required, from whom and when
Housework	☐	Can maintain home without help (including laundry)	
	☐	Need some assistance (cleaner, change light bulb)	
	☐	Completely unable to do housework	
Transport	☐	No help needed (drives own car, or travels independently on public transport or by taxi)	
	☐	Need some help (someone to drive or accompany when travelling)	
	☐	Can only travel in specialised vehicle	
Shopping (has transport)	☐	Can take care of all shopping needs on own (including internet shopping)	
	☐	Need some help (someone to accompany on most shopping trips)	
	☐	Completely unable to do any shopping	
Meal preparation	☐	No help needed (can plan, prepare, cook and ensure nutrition)	
	☐	Need some help	
	☐	Completely unable to prepare meals and manage nutrition	
Eating	☐	No help needed	
	☐	Some help needed (cutting up food, spreading butter, pouring drink, modified cutlery)	
	☐	Completely unable to eat without help (spoon feeding)	
Taking oral medication	☐	No help needed (right dose and right time)	
	☐	Need some help (someone prepares, reminds, pre-packed)	
	☐	Completely unable to take own medicines without help	
Handling money	☐	No help needed (banking, paying bills, keeping track of finances)	
	☐	Need some help (can manage day to day buying but needs help with paying bills)	
	☐	Completely unable to manage money	

Telephone	☐	No help needed (can make and receive phone calls including using assistive devices)	
	☐	Needs some help	
	☐	Completely unable to use telephone	
Mobility	☐	No help needed (except use of stick)	
	☐	Need some help (person, walker, crutches or self-propelled wheelchair including cornering)	
	☐	Completely unable to walk or needs to be pushed in wheelchair	
Transfers Bed/chair	☐	No help needed	
	☐	Need some help (person or equipment)	
	☐	Unable to manage (unable to balance while sitting)	
Bathing Showering	☐	No help needed (get in and out of bath/shower and wash unaided)	
	☐	Need some help (rails, shower chair, person to shampoo hair) but can wash themselves	
	☐	Completely unable to bathe/shower on own	
Oral care	☐	No help needed (includes using electric toothbrush)	
	☐	Need some help (prompting)	
	☐	Completely unable to manage mouth care and cleaning teeth	
Dressing	☐	No help needed	
	☐	Need some help (zips, buttons, laces but can put on some garments)	
	☐	Completely unable to dress	
Grooming (makeup, hair, nails, shaving)	☐	No help needed	
	☐	Need some help	
	☐	Completely unable to manage any grooming without help	
Toileting	☐	No help needed (can get on and off, remove clothing and clean thoroughly)	
	☐	Need some help	
	☐	Completely unable to manage toileting without help	

Tick all relevant boxes

Health requirements

Activity	Tick		Outline condition, treatments, aids/assistance required, from whom and when
Continence	☐	Continent with regular bowel and bladder action	
	☐	Constipation, diarrhoea or incontinence (using medication, supplements, pads)	
	☐	Medical interventions (catheter, stoma bag)	
Skin Integrity	☐	No skin problems	
	☐	Some skin problems (rash, skin treatments)	
	☐	Pressure areas (currently have, at risk, or had in past)	
Swallowing	☐	No swallowing issues	
	☐	Some swallowing problems (choking, coughing during normal meal, reduced appetite)	
	☐	Major swallowing difficulties (modified diet, feeding tube)	
Health professionals	☐	Have had a GP check up in the last 12 months	
	☐	See a specialist regularly	
	☐	Have a case manager/support coordinator	
Muscular pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	
Nerve pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	
Falls	☐	No falls in past 12 months	
	☐	Less than 3 falls and no serious injury from a fall in past 12 months	
	☐	More than 3 falls or a serious injury from a fall in the past year	
Muscular issues (other than pain)	☐	No problems	
	☐	Some muscle weakness, tremor, spasms, spasticity or problems with balance	
	☐	Serious muscle weakness, tremor, spasticity or problems with balance	
Other health concerns	☐	Fatigue	
	☐	Visual disturbance	
	☐	Temperature intolerance	
	☐	Other comorbidities	

Social Requirements

Activities	Outline how you want to do this activity	Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)
Example: I love cooking.	• I like to watch cooking shows on TV • I like to buy good cook books • I like to prepare my own meals • I like to attend cooking classes regularly	• I need a TV in my room with good reception. • I need a computer/tablet and high speed internet or Wi-Fi to buy books on line. • I would like to have access to a kitchen to prepare my own meals 2 x per week • I need a maxi taxi and carer/staff member to take me to cooking classes once a month
Family:		
Hobbies and Interests:		
Outings: e.g. theatre, cafes, exhibitions, drives, groups activities		
Computer: e.g. games, shopping, education, bookings		
Employment: Education, Volunteering		
Sports:		
Music: Likes, dislikes		
Movies/TV: Likes, dislikes		
Well-being: e.g. exercise, gym, swimming pool, massage, yoga, meditation etc.		
Food and alcohol: Likes, dislikes, diets		
Other:		

Behavioural requirements

Issue	Tick one	Assistance I need	Outline the issue, aids, assistance and management strategies required
Communication	☐	No assistance required (including independent use of aids and adaptive technology)	
	☐	Some assistance required (prompting, assistance with aids)	
	☐	Assistance always required	
Memory problems Confusion	☐	No	
	☐	Yes	
Concentration problems	☐	No	
	☐	Yes	
Planning problems	☐	No	
	☐	Yes	
Spiritual needs	☐	No	
	☐	Yes (name religion or spiritual affiliation and requirements)	
Mood	☐	Mostly positive	
	☐	Experiences sadness, anxiety or emptiness around 50% of time	
	☐	Feelings of anxiety, sadness or emptiness lasting most of the day, nearly every day	
Decision making	☐	No help needed	
	☐	Need some help	
	☐	Not able to make any decisions	
Do you have a Will?	☐	No	
	☐	Yes	
Do you have an Enduring Power of Attorney or Guardian?	☐	No	
	☐	Yes	
Do you have an Advance Care Plan?	☐	No	
	☐	Yes	

Behavioural requirements

What things are important for people to understand about you when caring for you?	Provide details	Outline how you like this to be managed
Who makes the decisions?		
What routines do you have?		
What makes you happy?		
What helps you relax?		
What causes you stress?		
What makes you frustrated?		
What makes you angry?		
Other		