



Cardiovascular Health Awareness Program + Action Plan
Programme de sensibilisation à la santé cardiovasculaire + plan d'action

Session Pharmacy ID

Grid for Session Pharmacy ID

CHAP+AP Mentorship Discussion Form

For each question, please solidly fill in one circle like this ● (NOT like this ⊗ or this ∅). Thanks!

- Did you participate in the CHAP 2006 program? Yes OR No
- Is this session the first visit or repeat visit to the CHAP+AP Program? First OR Repeat
- a. Have you completed an online Heart and Stroke Foundation Blood Pressure Action Plan™? Yes OR No
b. If yes, did you sign up for free on-going email support from Heart and Stroke Foundation? Yes OR No
- What priorities/goals were identified for you on your CHAP+AP Risk Profile Recording Form and/or Heart and Stroke Blood Pressure Action Plan™? (Fill in all that apply):
 Alcohol Blood Pressure Cholesterol Diabetes Physical activity
 Stress Fat Salt Smoking Weight
- What modifiable risk factors would you like to change? (Fill in all that apply):
 Alcohol Use Blood Pressure Cholesterol Diabetes Physical activity
 Stress Fat Salt Smoking Weight
- What risk factors did you discuss with the Peer Health Educator today?
 Alcohol Blood Pressure Cholesterol Diabetes Physical activity
 Stress Fat Salt Smoking Weight
- What community resources were offered to you today? (Fill in all that apply)
 Family Physician/Family Health Team provider Pharmacist / MedsCheck Dietitian Smoking cessation counselor
 Community program/Talk Social Worker Other: _____
- What information did you receive today to help you in achieving your priorities/goals? (Fill in all that apply and provide the name)
 Brochure or poster: _____
 Internet resource: _____
 Information on local community resource: _____
 Other: _____
- What steps are you planning to take to achieve priorities/goals based on today's discussion? (Fill in all that apply)
 Reviewing educational material See an allied health professional (select below):
 Increasing physical activity after consulting Family Physician Pharmacist / MedsCheck Dietitian Family Physician/ FHT Provider
 Attending/joining a community program Social Worker Smoking cessation counselor
 Other: _____
- Are you planning to return to a CHAP+AP session? Yes OR No

IF THIS IS A REPEAT VISIT TO CHAP+AP CONTINUE TO COMPLETE FORM

- Indicate which referral you followed up with since your last CHAP+AP session (Fill in all that apply):
 Community program/talk Pharmacist / MedsCheck Dietitian / smoking cessation counselor
 Family Physician/FHT provider Social Worker Other: _____
- Has a doctor recently diagnosed you with any of the following conditions?
 High blood pressure (hypertension) Diabetes High cholesterol
- Since your last CHAP+AP visit, has there been any change in any of the following? (Fill in all that apply and provide details):

Risk Factor	No Change	Increase	Decrease	Quit	Details
Smoking:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Alcohol use:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Eating high fat foods:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Eating fruits and vegetables:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Salt use:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Stress:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Physical activity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Weight:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Blood pressure:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Cholesterol level:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

OFFICE USE ONLY (Print in CAPS)

Date (___/___/2008) completed with _____ at _____

DD MM Volunteer Name Location

First 4 letters of Pt's Last Name Pt's Birth Date - -

(year) (3-letter mo.) (day)