



Cardiovascular Health Awareness Program  
Programme de sensibilisation à la santé cardiovasculaire

# CHAP Mentorship Discussion Form

Session Pharmacy ID

For each question, please solidly fill in one circle like this ●.

1. Is this session the first visit or repeat visit to the CHAP Program?     First    OR     Repeat
2. a. Have you completed an online Heart and Stroke Foundation Blood Pressure Action Plan TM?     Yes    OR     No  
 b. If yes, did you sign up for free on-going email support from Heart and Stroke Foundation?     Yes    OR     No
3. What priorities/goals were identified for you on your CHAP Risk Profile Recording Form and/or Heart and Stroke Blood Pressure Action PlanTM? (Fill in all that apply):  
 Alcohol     Blood Pressure     Cholesterol     Diabetes     Physical activity  
 Stress     Fat     Salt     Smoking     Weight
4. What modifiable risk factors would you like to change? (Fill in all that apply):  
 Alcohol     Blood Pressure     Cholesterol     Diabetes     Physical activity  
 Stress     Fat     Salt     Smoking     Weight
5. What risk factors did you discuss with the Volunteer Peer Health Educator today?  
 Alcohol     Blood Pressure     Cholesterol     Diabetes     Physical activity  
 Stress     Fat     Salt     Smoking     Weight
6. 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: \_\_\_\_\_
7. 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: \_\_\_\_\_
8. 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: \_\_\_\_\_
9. Are you planning to return to a CHAP session?     Yes    OR     No

**IF THIS IS A REPEAT VISIT TO CHAP CONTINUE TO COMPLETE FORM**

10. Indicate which referral you followed up with since your last CHAP session (Fill in all that apply):  
 Community program/talk     Pharmacist / MedsCheck     Dietitian / smoking cessation counselor  
 Family Physician/FHT provider     Social Worker     Other: \_\_\_\_\_
11. Has a doctor recently diagnosed you with any of the following conditions?  
 High blood pressure (hypertension)     Diabetes     High cholesterol
12. Since your last CHAP 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 (\_\_\_\_/\_\_\_\_/\_\_\_\_) completed with \_\_\_\_\_ at \_\_\_\_\_.

DD    MM    YR

Volunteer Name

Location

First 4 letters of Patient's Last Name   

Patient's Birth Date        -    -

(year)    (3-letter month)    (day)