CHAP
Cardiovascular Health Awareness Program
Programme de sensibilisation à la santé cardiovasculaire

Appendix 7.10

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
   ○ Increasing physical activity after consulting Family Physician
   ○ Attending/joining a community program
   See an allied health professional (select below):
   ○ Pharmacist / MedsCheck ○ Dietitian ○ Family Physician/ FHT Provider
   ○ 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:	○	○	○	○	
Alchol use:	○	○	○		
Eating high fat foods:	○	○	○		
Eating fruits and vegetables	○	○	○		
Salt use:	○	○	○		
Stress:	○	○	○		
Physical activity:	○	○	○		
Weight:	○	○	○		
Blood pressure:	○	○	○		
Cholesterol level:	○	○	○		
Other:	○	○	○		

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)

Program copy – White Community copy – Yellow Participant copy – Pink