PATIENT-CENTERED CARE PLAN

Patient name: __________________________________________________________ Date: ________________________________

Provider name: ____________________________________________________________________________________________

Complete the next four sections prior to your visit:

Top concerns and barriers
The main things I would like to fix or improve about my health are:

•

•

•

The main things preventing me from improving my health are:

•

•

•

Symptom management
The main symptoms I wish to reduce or eliminate are:

•

•

•

To treat these, your provider will help you complete the “Summary of things I need to do,” next page, at your appointment.

Health care providers
List any other providers you see regularly for health care (for example, ophthalmologist, cardiologist, therapist):

•

•

•

Resources and supports
Besides your health care team, who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?

•

•

Complete the remaining sections with your provider at your appointment:

My medications*

☐ I agree to do the following:
  • Discuss concerns I have about taking any of my medications with my primary care provider (PCP) and/or pharmacist,
  • Advise my PCP if I choose to stop my medication(s), including my reasons for stopping, and discuss potential alternatives,
  • Advise my PCP of bothersome side effects from my medication(s),
  • Inform my PCP if new medications are added by other providers.

☐ I have reviewed the current medication list (see above) and confirm that it is accurate.

My allergies*


My conditions*

☐ I have reviewed my list of conditions.

continued
Treatment goals/targets
These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100; BP <150/90; weight of 150 pounds; 7 hours of uninterrupted sleep; average pain level of 5; ability to walk to my mailbox daily):

•
•

Summary of things I need to do
List action needed and time frame for each item. If not applicable, indicate N/A or none:

Tests to complete
___________________________________________________________________________________________________________________

Other health professionals to see
___________________________________________________________________________________________________

Community resources to use
________________________________________________________________________________________________________

Medication changes to make
________________________________________________________________________________________________________

Other treatments to get
_____________________________________________________________________________________________________________

Health-related education to pursue
_________________________________________________________________________________________________

Short-term activities to do
__________________________________________________________________________________________________________

Lifestyle changes to make (for example, quit smoking, lose 10 pounds, buy a pedometer and walk 5,000 steps per day; SMART goals – specific, measurable, achievable, realistic, time-bound – are recommended):

Diet
_________________________________________________________________________________________________________________________________

Exercise
____________________________________________________________________________________________________________________________

Stress management
____________________________________________________________________________________________________________________

Safety
_____________________________________________________________________________________________________________________

Smoking
_____________________________________________________________________________________________________________________

Other habits
_____________________________________________________________________________________________________________________

Frequency of planned future appointments here: ________ per year

Care manager
If I need help arranging care outside this office or have questions or concerns about any of the things I need to do (above), I can contact:

Name: ___________________________________________ Phone/email address: ___________________________________________

☐ I will ask other providers to send a summary of their care to this office.

Expected outcomes/prognosis
If I follow the treatment/action plan above, I can expect the following to happen:

•
•
•

Patient signature: __________________________________________________________

Provider signature: __________________________________________________________

* Data for these sections may be imported from the patient record when this form is used as the basis for an electronic health record template. The following elements should also be incorporated: date created, patient name and identifiers, and provider name.