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.

* 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.
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: ______________________________________________________________________