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.

Family Practice Management®