## 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\* $\square$ 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\*

 $\square$  I have reviewed my list of conditions.

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:
$\square$ 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:

\* 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.



Provider signature: