# Community Care Plan

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| Date: Lead Care Coordinator: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Last Name: First: | | | | | | | | | Middle: | | | | | | | |  | | | | | ❑ Mr.  ❑ Mrs. | | ❑ Miss  ❑ Ms. | | | | | | | Phone Number: | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | |
| Is this your legal name? | | | | If not, what is your legal name? | | | | | | | | | | Former name: | | | | | | | | | | | | | | Birth date: | | | | | Age: | | | | Sex: | | |
| ❑ Yes | | ❑ No | |  | | | | | | | | | |  | | | | | | | | | | | | | | / / | | | | |  | | | | ❑ M | ❑ F | |
| Address: | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | | Marital Status: | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | Single / Mar / Div / Wid / Sep | | | | | | | | |
| City: | | | | | | | | | | | | State: | | | | | Zip: | | | | | | | | | | | | | | Advanced Directive: | | | | | | | | |
|  | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | ❑ Yes ❑ No | | | | | | | | |
| Diagnosis: | | | | | | | | | | | | PCP Care Coordinator: | | | | | | | | | | | | | | | | | | | 10 Year Medical Record Review Completed:  ❑ Yes ❑ No | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Collaborative Release signed: ❑ Yes ❑ No | | | | | | | | |
| PCP:    Care Team: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Care plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PErson(s)Responsible Due Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Treatment Goals: | | |  | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | |
|  | | |  | |  | |  | | |  | | | | | | | | |  | | | | | | | | | | | |  | | |  | | | | | |
| Patient Goals: | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | |
| Strengths/  Preferred activities: | | |  | | | | | | | | |  | | | | | |  | |  | | | | | | | | | |  | | | | | |  | | | |
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| Potential Barriers: | | |  | | | | | | | | | | | | | | | |  | |  | | | | | | | | | |  | | | |  | | | | |
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| Action / Self- management Plan: | | |  | | |  | | | | |  | | | | | |  | |  | |  | | | | |  | | | | | | | | |  | | | | |
| Tips to Avoid Triggers/behaviors | | |  | | |  | | | | |  | | | | | |  | |  | |  | | | | |  | | | | | | | | |  | | | | |
| Additional comments/concerns | | |  | | |  | | | | |  | | | | | |  | |  | |  | | | | |  | | | | | | | | |  | | | | |
| Care plan last updated: | | | | | | Next Appointment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative: | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | Home phone no.: | | | | | | | | Work phone no.: | | | | | | |
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