# Community Care Plan

|  |
| --- |
|  |
| 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:  |
|   |
|  |
| Care plan |
|  PErson(s)  Responsible Due Date |
| Treatment Goals: |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Patient Goals: |  |  |  |
| Strengths/Preferred activities: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Potential Barriers: |  |  |  |  |  |
|  |  |  |  |  |
| Action / Self- management Plan: |  |  |  |  |  |  |  |  |
| Tips to Avoid Triggers/behaviors |  |  |  |  |  |  |  |  |
| Additional comments/concerns |  |  |  |  |  |  |  |  |
| Care plan last updated:  |  Next Appointment: |  |
|  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative: | Relationship to patient: | Home phone no.: | Work phone no.: |
|  |  | ( ) | ( ) |
|  |  |  |