

CCC Patient Plan Template

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| --- | --- | --- | --- | --- | --- | --- | --- |
| General Information | | | | | | | |
| Patient Name: | | | | | | Phone: | |
| Emergency Name: | | | | | | Phone: | |
| Alternate Emergency: | | | | | | Phone: | |
| Primary Care Provider: | | | | | | Phone: | |
| Specialist (Type: ): | | | | | | Phone: | |
| Specialist (Type: ): | | | | | | Phone: | |
| Care Coordinator: | | | | | | Date CCC Started: | |
| Advance Directives: | | | | | | Date: | |
| Current Problem List | | | | | | | |
| Problem | | Onset Date | | Provider | | Education Supplied | Pt Response to CCC |
| 1. | |  | |  | |  |  |
| 2. | |  | |  | |  |  |
| 3. | |  | |  | |  |  |
| 4. | |  | |  | |  |  |
| 5. | |  | |  | |  |  |
| 6. | |  | |  | |  |  |
| 7. | |  | |  | |  |  |
| 8. | |  | |  | |  |  |
| 9. | |  | |  | |  |  |
| 10. | |  | |  | |  |  |
| Current Medication List Allergies: ❑ PCN ❑ Sulfa ❑ Other: ❑ Food: | | | | | | | |
| Medication Name | Dose | | Route | | Sig | Prescriber | Compliance/  Needs |
| 1. |  | |  | |  |  |  |
| 2. |  | |  | |  |  |  |
| 3. |  | |  | |  |  |  |
| 4. |  | |  | |  |  |  |
| 5. |  | |  | |  |  |  |
| 6. |  | |  | |  |  |  |
| 7. |  | |  | |  |  |  |
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| 9. |  | |  | |  |  |  |
| 10. |  | |  | |  |  |  |

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| Health Risks | | | | | Management | | | |
| * Functional status: | | | | |  | | | |
| * Health literacy: | | | | |  | | | |
| * Environmental: | | | | |  | | | |
| * Computer literacy: | | | | |  | | | |
| * Financial: | | | | |  | | | |
| * Psychosocial/behavioral | | | | |  | | | |
| * Other? | | | | |  | | | |
| Current treatment plan, provider appointments, diagnostic studies | | Provider | | Date Due | Compliance Needs | | Results | |
|  | |  | |  |  | |  | |
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| Lifestyle changes applicable  [List goals here (for each box)] | Goal (Y/N) | | Confident  (1-10) | Barriers | Needs | Report to/ Frequency | | Results |
| ❑ Diet (e.g., instruction, nutrition, financial) |  | |  |  |  |  | |  |
| ❑ Exercise (e.g., instruction, buddy assistance) |  | |  |  |  |  | |  |
| ❑ Tobacco cessation (e.g., support group, medication) |  | |  |  |  |  | |  |
| ❑ Alcohol and substance (e.g., support group, medication) |  | |  |  |  |  | |  |
| ❑ Sleep (e.g., instruction, medication) |  | |  |  |  |  | |  |
| ❑ Mood (e.g., instruction, referral to social worker) |  | |  |  |  |  | |  |
| ❑ Other? |  | |  |  |  |  | |  |

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| Home Monitoring Needs | | Instruction / Assistance needs | Performed |
| ❑ Blood pressure | |  |  |
| ❑ Blood sugar | |  |  |
| ❑ Pulse oximeter | |  |  |
| ❑ Scale | |  |  |
| ❑ Medication reminder system | |  |  |
| ❑ Health diary | |  |  |
| ❑ Other? | |  |  |
| ❑ Other? | |  |  |
| ❑ Other? | |  |  |
|  | | | |
| Contacts/Notes  Pt Preferred Communications: ❑ Call\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Text\_\_\_\_\_\_\_\_\_\_\_ ❑ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Date/Time:  ❑ Call  ❑ Text  ❑ Email | Notes: | | |
| Date/Time:  ❑ Call  ❑ Text  ❑ Email | Notes: | | |
| Date/Time:  ❑ Call  ❑ Text  ❑ Email | Notes: | | |

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