Shared Care Plan

Patient Information

Patient's Name:			Mobile Phone Number:	
Birthdate:	Age:	Sex:	Home Phone Number:	Email Address:
Address:			Preferred Method of communication: ☐ Phone ☐ Email ☐ Text ☐ Other:	

Insurance Information

Primary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:
Secondary Insurance:		ID Number:
Policy Holder:	Policy Holder birthdate:	Employer:

Emergency Contact Information

Name:	Relationship:
Home Phone Number:	Work Phone Number:
Legal Decision Maker Information:	

ED Plan

About Me

Insert picture here	Preferred activities:
	How I learn:
	Interaction tips:
	Communication style:
	Tips to avoid triggers/behaviors:
	Mobility:

My Care Plan

My Care Team			
Lead Care Coordinator:		Phone:	
Organization:		Email:	
Primary Care Physician:		Phone:	
Organization:		Email:	
Name	Organization & Role	Email	Phone Number

My Strengths

My Goals			
Personal Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

Medical Goals	Steps needed to achieve the goal	Person Responsible	Date Completed
1.			
2.			
3.			
4.			
5.			

Possible challenges with meeting a goal	Plans for how to handle these challenges

Future Goals

Participant's signature _____ Date:_____

Lead Care Coordinator's signature _____ Date:_____