COMMUNITY CARE PLAN

Date:		Lead Care Coordinator:				
PATIENT INFORMATION						
Patient Last Name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Phone Number: ( )	
sIs this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ❑ 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 Done: ❑ Yes ❑ No	
PCP: Care Team:						

CARE PLAN			
		PERSON RESPONSIBLE	**DUE DATE**
Treatment Goals:			
Patient Goals:			
Shared Strengths:			
Potential Barriers:			
Action / Self-management Plan:			

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

		( )	( )