



PATIENT-CENTERED CARE PLAN INITIATION

Patient: _____ Date of Birth: _____

Provider Name: _____

Top concerns

The main things I would like to improve about my health are:

The main things preventing me from improving my health are:

Are there any external barriers preventing you in achieving your goals:

Symptom management

The main symptoms I wish to reduce or eliminate are:

Additional Support

Besides your health care team, who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?

Treatment goals/targets

Mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100; BP <150/90; weight of 150 pounds; 7 hours of uninterrupted sleep; average pain level of 5; ability to walk to my mailbox daily):

Frequency of planned future appointments here: _____ per year

Care manager

Our office has arranged for your care management to be administered by RevUp

I will ask other providers to send a summary of their care to RevUp (866) 716-0083

Expected outcomes/prognosis

If I follow the treatment/action plan above, I can expect the following to happen:

Patient signature: _____

Provider signature: _____

Care Management Consent form reviewed

Do you have a smart phone?

Yes No

If yes, are you willing to download an app as a method of communication for your care?

Yes No

Would you prefer receiving texts or calls for your regular check in?

Text Call

Cell Phone Number: _____