U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30329

Complete Care Plan

Reset Form

Complete THIS FORM with the information about the PERSON RECEIVING CARE
A care plan summarizes a person's health conditions and current treatments for their care

First Name: _____ Last Name: _____

Date of birth: _____ Age: _____ Phone number: _____

Address: _____ E-mail: _____

About the person receiving care – *This information will help your caregivers to know you better and plan activities that you enjoy*

In a few sentences, tell people what you want them to know about you. *What is your family like? Where did you grow up? What kind of activities do you like doing (walking, sitting by the garden, playing cards, watching a TV show)? What things are you interested in learning about?*

My Medical Conditions

Condition	Healthcare Provider for this condition	Medicine(s) I take for it	Things that help (resting, exercising)



Complete Care Plan
Complete THIS FORM with the information about the PERSON RECEIVING CARE

My Medications

Name of medicine	Medication instruction (needs refrigeration, take on empty stomach)	Dose	When I take it

My Healthcare Providers

Name	Specialty	Address	Phone number

My Healthcare Insurance

Health Insurance Provider	Telephone

My Preferred Hospital

Hospital Name	Address	Telephone



Complete Care Plan
Complete THIS FORM with the information about the PERSON RECEIVING CARE

Caregiver Resources

Service Provided (Driving, adult day care, meals, helpers, etc.)	Name of provider or helper	Telephone

Advanced Care Planning**

Check the medical Advanced Care Planning topics that you have discussed with your health care provider:

☐ **Advanced Directive or Living Will**
This is a legal document (not a medical order), to appoint someone as your legal representative and provides instructions about how you wish to be treated and cared for at the end of your life. Because it is not a medical order, it is not used to help doctors, emergency medical technicians, or hospitals treat you in an emergency.

☐ **Power of Attorney**
This legal document is used for you to give a specific person the ability to make decisions for you when you are unable to do so. It can be a spouse, adult child, family member, or friend. You can also name an alternate person in case something happens to the primary person you name. The power of attorney is usually part of the Advanced Directive, but is sometimes a separate document. Sometimes, depending on where you live, it is called a "medical (or healthcare) power of attorney," "medical proxy," or "healthcare agent."

☐ **Physician (or Medical) Orders for Life-Sustaining Treatment (POLST or MOLST) or Physician Orders for Scope of Treatment (POST)**
This document, which varies by state, is a medical order signed by a medical professional and used for treatment. It is generally used when a person is nearing the end of life, such as with a terminal or serious illness. This is a document that your doctor can discuss with you during your Advanced Care Planning discussion. This does not name a "surrogate" or "medical proxy." This document would be used together with the Living Will/Advanced Directive to guide your loved ones and your doctors in the event that you are unable to make your own decisions

The following documents will be attached to this Care Plan:

☐ Advanced Directive or Living Will

☐ Power of Attorney

☐ Orders for Life-Sustaining Treatment or Scope of Treatment

**Information provided by the American College of Physicians.

Plans for follow-up

Ask your medical provider to explain situations when you should call the doctor's office, report to an emergency room, or schedule a regular follow-up appointment. *What are signs and symptoms you and/or your caregiver should look out for? Make sure you write on a calendar all appointments for all caregivers to see.*



Complete Care Plan
Complete THIS FORM with the information about the PERSON RECEIVING CARE

Emergency Contacts

Name	Relation	Phone number	Address

- I have thought about what medical treatment will mean for me and have discussed it with my family, caregivers, and medical providers
- This plan reflects an outline of my current medical management and plans along with those involved in my medical care.

I have given a copy of my Care Plan to:

Title	Full Name	Phone number	Address
Doctor			
Family			
Friend			
Other			

Daily Care Plan

Complete this form with the information about the PERSON RECEIVING CARE and DISPLAY it where all caregivers can SEE IT.

First name: _____ Last name: _____ Date of birth: _____ Age: _____

Phone number: _____ Address: _____

My Medical Conditions

Condition	Healthcare Provider I see for this condition	Medicine(s) I take	Things that help (resting, exercising)

My Medications

Name of medicine	Medication instruction (needs refrigeration, take on empty stomach)	Dose	When I take it

Emergency Contacts

Name	Relation	Phone number	Address

Advanced Care Planning and Insurance Information

My Medical Power of Attorney is (Name): _____ Phone number: _____

Insurance Information- Provider: _____ Telephone: _____

Email Form Print Form Save Form