BlueCross BlueShield of Oklahoma

Patient Visit/Action Care Plan

Patient Name:	**Primary Care Physician:**
DOB:	**Care Manager:**
Age:	**Care Team:**

Chronic Conditions

- ☐ Diabetes
- ☐ Hypertension
- ☐ BMI <19 or >30
- ☐ COPD/Asthma
- ☐ CAD/CHF
- ☐ Depression
- ☐ Other:_____
- ☐ _____

Current A1c _____

Current B/P _____

Current BMI_____

Risk Stratification Score:_____

Prescription Medications – Use additional page if needed

Name	Dose	Route	When Taken	Why Taken	Additional Information

Other Concerns	Allergies	
	Item/Medication	**Additional Information**

Patient Name:	**Primary Care Physician:**
DOB:	**Care Manager:**
Age:	**Care Team:**

Current Self-Management

Diet:	**Physical Activity:**
Checking: B/P, Glucose Frequency?	**What type of Device/s Used:**

Health Screening and Maintenance

- ☐ Flu Shot — Received: _____
- ☐ Pneumococcal Vaccination — Received: _____
- ☐ Zoster Vaccination — Received: _____
- ☐ Stool for OB — Completed:_____
- ☐ Colon/signoid-oscopy — Completed:_____
- ☐ Dexa Scan (woman) — Completed:_____
- ☐ Mammogram (woman) — Completed:_____
- ☐ Cervical Cancer Screening — Completed:_____
- ☐ PSA (men) — Completed:_____
- ☐ Smoking Cessation Program (Note if not applicable) — Completed:_____
- ☐ Nutrition Evalution (Note if not applicable) — Completed:_____
- ☐ Weight Management (Note if not applicable) — Completed:_____
- ☐ PT/OT/ST/Home Health/Hospice Referral (Note if not applicable) — Completed:_____
  Completed:_____
- ☐ Podiatry Exam (Note if not applicable) — Completed:_____
- ☐ Eye Exam — Completed:_____
- ☐ BMI — Completed:_____
- ☐ Falls/Safety Prevention — Completed:_____
- ☐ PHQ2 — Completed:_____
- ☐ PHQ9 — Completed:_____
- ☐ GAD7 — Completed:_____
- ☐ Polst — Completed:_____
- ☐ Advanced Directive — Completed:_____ — On File: _____

Patient Name:	**Primary Care Physician:**
DOB:	**Care Manager:**
Age:	**Care Team:**

Psychosocial needs:

Barriers to care: (transportation, finances, lack of family or social support)
Caregivers involved:
Home health:
Single level vs. Multilevel home, How many stairs if any to get in and out of your house:
ADLS: (is patient able to dress, bath, make meals, get out of bed.)
Does patient administers their own meds, fill pill boxes:
Equipment: (Use of walker, cane, Oxygen, shower chair, hospital bed.)
If applicable is pt. actively undergoing Chemo or Radiation? Intervals of treatment?

Recent Hospitalizations or ER/Urgent Care Visits
Other Providers/Chiropractors/Specialist Seen

Patient Name:	**Primary Care Physician:**
DOB:	**Care Manager:**
Age:	**Care Team:**

Other Medical Changes

Action Plan and Shared Decision Making:		
Treatment Plan	**Goals**	**Notes**

In Agreement With Action Plan and Shared Decision Making

☐ Patient/Caregiver Date: _____

☐ Care Manager Date: _____

☐ PCP Date: _____