Chronic Illness Care Plan

Date: _____

Patient Name: _____

Patient ID: _____

Diagnosis

Chronic Condition: _____

Additional Conditions: _____

Goals of Care

1. Short-term goals: _____
2. Long-term goals: _____

Treatment Plan

Medications

Medication Name: _____

Dosage: _____

Frequency: _____

Therapies/Interventions

Type of Therapy: _____

Frequency: _____

Monitoring and Follow-up

Next Appointment: _____

Monitoring Parameters: _____

Emergency Plan

If symptoms worsen, contact: _____

Patient Education

Topics Covered: _____

Signatures

Provider Name: _____

Provider Signature: _____

Date: _____