Chronic Illness Care Plan Modification

Date: [Insert Date]

Patient Name: [Patient's Name]

Patient ID: [Patient's ID]

Provider Name: [Provider's Name]

Provider Contact Information: [Provider's Contact Info]

Current Care Plan Summary:

[Insert summary of the current care plan and relevant details]

Reason for Modification:

[Describe the reason for modifying the care plan]

Proposed Modifications:

- [Modification 1]
- [Modification 2]
- [Modification 3]

Goals of the Modified Care Plan:

[Insert the goals associated with the modified care plan]

Next Steps:

[Outline the next steps for implementation and follow-up appointments]

Patient Acknowledgment:

I, [Patient's Name], acknowledge the proposed modifications to my care plan.

Signature: _____ Date: _____

Provider Signature:

Provider Signature: _____ Date: _____