Care Plan

Discuss care plan with patient. Complete the form based on agreed plan, sign and give a copy to patient.

Patient Name:_____ Date:_____

CARE TEAM

Name	Address	Phone Number	E-mail Address
Doctor			
Navigator			

☐ Accompaniment to medical visits ☐ Reminders for visits by: ☐ Call ☐ Text ☐ Email

CHECK HEP C PROGRAM GOALS

Goal	Date Completed
☐ Complete patient navigation assessment	
☐ Receive "Hep C basics" health promotion	
☐ Receive "Getting ready for Hep C care" health promotion	
☐ Attend 1st Hep C medical visit	
☐ Complete Hep C medical evaluation	
☐ Receive "Getting ready for treatment" health promotion	
☐ Start Hep C treatment	
☐ Complete Hep C treatment	
☐ Receive "After treatment" health promotion	

REFERRALS

Type of Service	Site Name and Address	Phone Number/ E-mail Address	Appointment Date/ Time
☐ Mental health			
☐ Alcohol counseling			
☐ Transportation services for national programs			
☐ Substance use/harm reduction			
☐ Insurance enrollment			
☐ Benefits (Food/ financial)			
☐ Housing services			
☐ Legal services			
☐ Specialist:			
☐ Other:			

Care Plan

HEALTH GOALS

Action	How	By when
☐ Reduce or stop drinking alcohol		
☐ Reduce or stop using drugs		
☐ Reduce or stop smoking		
☐ Work towards a healthy body weight		
☐ Review all meds and supplements with doctor		
☐ Manage other illnesses		
☐ Other:		

NOTES

Navigator Signature_____ Date_____

Patient Signature_____ Date_____