Comprehensive Care Plan: Hypertension

Name:_____ Date of Birth: _____ PCP:_____

Date Care Plan initiated:_____

1. How do you see the **importance** of making ANY change in how you are currently managing hypertension? (1=Low 10=High)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. How do you see your **readiness** to make ANY change in managing hypertension? (1=Not ready 10= Very ready)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. How do you see your **confidence** in making ANY change in how you are currently managing hypertension? (1= Not confident 10=Very confident)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Personal Goal Plan

The goal I have chosen is:

Barriers to achieving this goal:

Benefits of achieving this goal:

Plan to work on this goal:

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Your health care provider will give input on the following:

My current blood pressure is:_____ My goal blood pressure is:_____

Current blood pressure medication(s) and dosing:_____

How often and when to check blood pressure:_____

What are you currently doing to manage your blood pressure?

What is working well for you with managing your blood pressure?

What did not work for you with managing your blood pressure?

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WOULD YOU LIKE TO LEARN MORE ABOUT ANY OF THE FOLLOWING: (Check all that are of interest)

☐ Understanding hypertension	☐ Activity tracking	☐ Stress management
☐ DASH diet	☐ Mood/Depression	☐ Reduce alcohol consumption
☐ Decrease salt intake	☐ Hypertension medication	☐ Anxiety management
☐ Monitoring blood pressure	☐ Smoking cessation	☐ Sleep apnea
☐ Monitoring weight	☐ Physical activity/Exercise	☐ Other:_____

HOW WOULD YOU PREFER TO BE CONTACTED BY THE CARE COORDINATOR:

❑ Phone calls ❑ MyChart messaging ❑ Face-to-Face visits

Frequency for contacting:_____

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Care Plan Updates:

Date:

Outcome/Care Plan Change:

Date:

Outcome/Care Plan Change:

Date:

Outcome/Care Plan Change: