

 **Care Plan**

**NAME:**

**DOB:**

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| **Important to know**  |
| **Contact Information**  | **Medication Reconciliation**  | **Medical Action Plans**  |
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| **About Me** |
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| **Devices** |
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| **Diet** |
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| **Pharmacy**  |
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| **Providers**  |
| **Name & Specialty**  | **Address, Phone Number and Fax**  | **Following for, medications managed and/or action plan prescribed**  |
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| **Resources in place** |
| **Name**  | **Company, Address, Phone Number and Fax**  | **Services Provided**  |
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| **What we are currently working on**  |
| **Items/Goals to stabilize health** | **Date Achieved** |
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| **Items/Goals for child and family well-being** | **Date Achieved** |
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| **Family Notes**  |
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