



COMMUNITY HEALTH CENTERS  
OF THE RUTLAND REGION

## Self-Management Plan

Hypertension (HTN)    Atrial Fibrillation (A-Fib)    Diabetes (DM)

Date: \_\_\_\_\_

Nurse: \_\_\_\_\_

Name: \_\_\_\_\_

Provider: \_\_\_\_\_

DOB: \_\_\_\_\_

### **Things I should do for my chronic condition:**

1. Limit alcohol and caffeine
2. Avoid tobacco products
3. Maintain a healthy weight
4. Avoid stress and sleep regularly
5. Understand the goals of my treatment
6. Take my medicine as prescribed
7. Meal Plan: \_\_\_\_\_
8. Activity/Exercise Plan: \_\_\_\_\_
9. New medication/Dose changes: \_\_\_\_\_

### **I use the following Referral/Services:**

- |   |  |
|---|--|
| <input type="checkbox"/> Mental Health Counseling/Social Worker | <input type="checkbox"/> Home Health/ VNA                |
| <input type="checkbox"/> Cardiologist: _____                    | <input type="checkbox"/> Exercise/Fitness Program        |
| <input type="checkbox"/> Chronic Disease Care Management        | <input type="checkbox"/> Tobacco Cessation               |
| <input type="checkbox"/> Dietician/DM Education: _____          | <input type="checkbox"/> Date of last Dental Exam: _____ |
| <input type="checkbox"/> Healthy Living Workshop: _____         | <input type="checkbox"/> Date of last Eye Exam: _____    |
|   | <input type="checkbox"/> Other: _____                    |

### **Home monitoring:**

I Check my weight, \_\_\_\_\_ times per week

#### ***(For Diabetes):***

I Check my Blood Sugar, \_\_\_\_\_ days per week

2 Hours after my largest meal of the day

Before Breakfast    Before Lunch    Before Dinner

I Check my feet daily for sores and redness (call provider immediately with any changes)

I Wear shoes and socks that fit well

#### ***(For Atrial Fibrillation/Hypertension)***

I Check my Blood Pressure, \_\_\_\_\_ times per Day/Week (circle one)

I Check my Pulse, \_\_\_\_\_ times per Day/Week (circle one)

### **I will call immediate assistance (911) if:**

- Unexplained chest pain, pressure or shortness of breath
- Unexplained faintness, lightheadedness, dizziness or loss of balance
- Develop a sudden, severe headache with no known cause
- Unanticipated bleeding or bruising
- Unusual palpitations or increased heart rate
- I experience sudden weakness or numbness of my face, arm or leg
- I am suddenly confused or have trouble with speaking or understanding

**Patient/Family Readiness for change:**

- Thinking about it
- Ready to begin
- Preparing
- In progress
- Actually involved

**Patient's Goals for today is:** \_\_\_\_\_

- Patient declines goal setting

D= Date	D	Goal	D	Goal	D	Goal
Weight						
BMI						

**My goals:**

D=Date	Goal	D	D	D	D
Blood Pressure					
LDL					
A1C (DM)					
Heart Rate (HTN/A-Fib)					
Fasting Sugar (HTN/DM)					

**Patients Assessment of their Action Plan:**

How important is this?  
Important (0-10) \_\_\_\_\_ (0 is lowest score)

How confident are you?  
Confidence level (0-10) \_\_\_\_\_ (0 is lowest score)

**Barriers to Success (describe when necessary):**

- Education: \_\_\_\_\_
- Family: \_\_\_\_\_
- Financial: \_\_\_\_\_
- Insurance: \_\_\_\_\_
- Language: \_\_\_\_\_
- Lifestyle: \_\_\_\_\_
- Pain: \_\_\_\_\_
- Timing: \_\_\_\_\_
- Transportation: \_\_\_\_\_
- Physical Limitations: \_\_\_\_\_
- Other: \_\_\_\_\_
- None Identified

<b><u>Changes and/or Additions made during visit:</u></b>		
<b>Medication:</b>	<b>Diet:</b>	<b>Referrals:</b>

**Self Monitoring Tool Given:**

- Blood Sugar
- Blood Pressure
- Weight

**Follow-Up Plan:**

**(Call or set up appointment):**  
 < 1 Month  Office  Phone  
 3 Month  Office  Phone  
 6 Month  Office  Phone  
 12 Month  Office  Phone  
 Other: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_