

CCM Documentation

Patient information	
Name:	Date of birth:
Contact number:	
Address:	
Primary insurance:	Secondary insurance:
Patient consent	
Consent type:	Consent date:
<input type="checkbox"/> Verbal <input type="checkbox"/> Written	
Cost-sharing responsibility acknowledged:	Patient right to withdraw explained:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recorded in EHR:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Comprehensive care plan	
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Chronic conditions:	Date diagnosed:
Measurable treatment goals	
Goal 1:	Goal 2:

Medical management			
Medication name:		Dosage:	
Medication name:		Dosage:	
Medication name:		Dosage:	
Medication name:		Dosage:	
Medication name:		Dosage:	
Medication name:		Dosage:	
Medication name:		Dosage:	
Coordination with other providers			
Provider name:		Role in care:	
Communication date:			
Time documentation			
Month:		Total non-face-to-face time:	minutes
Record review: minutes		Care plan updates:	minutes
Communication with providers:		minutes	
Use of certified EHR systems			
EHR system used:			
Compliance with meaningful use criteria: <input type="checkbox"/> Yes <input type="checkbox"/> No		Health information structures and accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Regular updates and reviews			
Care plan review date:			
Update made:			