



SELF-MANAGEMENT ACTION PLAN

Patient Name:		Date:	
Staff Name:	Staff Role:	Staff Contact Info:	
Goal: <i>What is something you WANT to work on?</i>			
1.			
2.			
Goal Description: <i>What am I going to do?</i>			
How:			
Where:			
When:		Frequency:	
How ready am I to work on this goal? (Circle number below)			
Not  Very			
Ready 1 2 3 4 5 6 7 8 9 10 Ready			
Challenges: <i>What are barriers that could get in the way & how will I overcome them?</i>			
1.			
2.			
3.			
What Supports do I need?			
1.			
2.			
3.			
Follow-up & Next Steps (Summary):			
1.			
2.			
3.			
How confident do I feel about this action plan? (circle number below)			
Not  Very			
Confident 1 2 3 4 5 6 7 8 9 10 Confident			