SELF-MANAGEMENT ACTION PLAN

Patient Name:	**Date:**

Staff Name:	**Staff Role:**	**Staff Contact Info:**

Goal: *What is something you WANT to work on?*

1.

2.

Goal Description: *What am I going to do?*

How:

Where:

When:	**Frequency:**

How ready am I to work on this goal? (Circle number below)

Not Ready 1 2 3 4 5 6 7 8 9 10 Very Ready

Challenges: *What are barriers that could get in the way & how will I overcome them?*

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 Confident 1 2 3 4 5 6 7 8 9 10 Very Confident