

 <p><b>Care Management Plan</b> <b>Medicare Item No. 721</b></p> <p>Facility: _____</p>		<p>(Affix identification label here)</p> <p>URN: _____</p> <p>Family name: _____</p> <p>Given name(s): _____</p> <p>Address: _____</p> <p>Date of birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>
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Health problems and relevant conditions	Agreed management goals
1	
2.	
	<b>Actions to be taken by the patient</b>
3.	
	<b>Arrangements to provide treatment and services to the patient (when, who, contact details)</b>
4.	

Copy of plan provided to patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient signature: _____	Date: _____ / ____ / ____	Recall and review date due: _____ / ____ / ____	Medicare Item No. 721 claimed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date: _____ / ____ / ____	Doctors name (print): _____	Doctors signature: _____
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I have explained the steps involved with this care plan and the client has agreed to proceed with this service?  Yes  No



**Care Management Plan**  
Medicare Item No. 721

Facility: \_\_\_\_\_

(Affix identification label here)

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Date: _____ / ____ / ____	Doctor name (print): _____	Doctor signature: _____
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I have explained the steps involved with this care plan and the patient has agreed to proceed with this service  Yes  No