

## Chronic Care Management Minute-Sheet

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Visit Number: \_\_\_\_\_

Minutes	Reason	Minutes	Reason
	CCM Enrollment		Lab Results
	Care Plan		Medication management
	Review Care Plan		Prior Authorization
	Gaps in care		Referral
	ACO Measures		Record review
	Medication reconciliation		Call for records
	INR results		Patient call

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time completed by: \_\_\_\_\_ Total Time: \_\_\_\_\_

### HOSPITAL DISCHARGE

Facility	
Called for records	Date: _____ Time: _____ By: _____
Records received	Date: _____ Time: _____ By: _____
Med list received	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis	
PCP Follow Up	Date: _____ Time: _____