CHRONIC KIDNEY DISEASE ACTION PLAN

VERMONT CHRONIC CARE INITIATIVE
Healthy Together

Name: _____

Medical Provider's	Clinical Case Manager's
Name: _____	Name: _____
Phone: _____	Phone: _____

THINGS TO DO EVERYDAY:

- ☐ Take my medicines as directed

FILL OUT THE INFORMATION BELOW WITH MY MEDICAL PROVIDER FOR DAILY USE:

- ☐ Salt Restriction: _____
- ☐ Liquid Restriction: _____
- ☐ Protein Restriction: _____
- ☐ Cholesterol Restriction: _____
- ☐ Alcohol Use: _____
- ☐ Caffeine Use: _____
- ☐ Blood Sugar between: ___ and ___ _____
- ☐ Activity/Exercise: _____
- ☐ Healthy Weight: _____
- ☐ Blood Pressure: _____

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:

MY PLAN:

I will call my medical provider today if:

- ☐ I have problems taking my medicines
- ☐ I want to take "over the counter" OTC medicines, vitamins or herbal supplements
- ☐ I have new or increased swelling in my hands or feet
- ☐ I am short of breath
- ☐ My blood sugars are outside the target range: _____ to _____
- ☐ I have frequent or severe episodes of chest pressure or pain
- ☐ I have nausea, vomiting, light-headedness or leg cramps all the time
- ☐ I am urinating less, or my urine is dark in color
- ☐ I have unexplained headaches

I WILL DISCUSS WITH MY MEDICAL PROVIDER:

- ☐ Pneumonia vaccine
- ☐ Yearly flu vaccine

I WILL CALL 911 IF:

- ☐ I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea that doesn't go away with rest or after taking my medicine.
- ☐ I have sudden weakness or numbness of my face, arms or legs
- ☐ I have a sudden, severe headache with no known cause
- ☐ I have sudden confusion, trouble speaking or understanding others
- ☐ I have sudden loss of balance, dizziness or difficulty seeing

THINGS TO AVOID:

- ☐ Food high in salt or using salt substitutes _____
- ☐ Tobacco products _____
- ☐ Antacids with aluminum or magnesium _____
- ☐ Ibuprofen/naproxen _____
- ☐ Smoked, cured or canned meat _____
- ☐ Aspirin if more than 81mg daily _____

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MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)	Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important	1	2	3	4	5	6	7	8	9	10	Totally important
	○	○	○	○	○	○	○	○	○	○	

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident
	○	○	○	○	○	○	○	○	○	○	

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):