Health Care Management Plan

Name:		DOB:		Date of ISP:	
Address:	City:	State:	Zip:		
Home Phone:		Agency Phone:			
Weight:	Height:	Sex:	Race:	Hair:	Eye color:
Name of RN:		Signature:	Revision Date:		Review Date:

RISK AREA or CONDITION Specify Concern	**DESIRED OUTCOME**	**RN/LPN INTERVENTION** Reference any protocols that are in use (i.e. feeding or positioning); Include the frequency & schedule of the intervention	**DSP INTERVENTION** Reference any protocols that are in use (i.e. feeding or positioning); Include the frequency & schedule of the intervention
Cardiovascular			
Endocrine			
Infectious Disease			
Pulmonary			

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Neurology			
Psychiatry			
Autoimmune			
Gastrointestinal			

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Nutritional			
Hematological			
Skin			
Musculoskeletal / Extremities			

RISK AREA or CONDITION Specify Concern	**DESIRED OUTCOME**	**RN/LPN INTERVENTION** Reference any protocols that are in use (i.e. feeding or positioning); Include the frequency & schedule of the intervention	**DSP INTERVENTION** Reference any protocols that are in use (i.e. feeding or positioning); Include the frequency & schedule of the intervention
Gynecological			
Urological			
Habits			
Behavior			
Other Risk Factors			