Health Care Management Plan

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| --- | --- | --- | --- |
| 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** |  |  |  |