

Plan reviewed with patient Yes No
 Plan reviewed with family Yes No
 Plan reviewed with significant other Yes No
 If NO, Explain: _____

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PLAN OF CARE

PATIENT IDENTIFICATION

DATE / INITIAL	PROB. NO.	PROBLEMS RELATED TO (NURSING DIAGNOSIS)	EXPECTED OUTCOME (SHORT TERM GOAL)	NURSING INTERVENTION (NURSING ORDERS)	FREQUENCY	DATE RESOLVED	INITIAL
	1	<input type="checkbox"/> Physiologic Problems					
		<input type="checkbox"/> Lack of Knowledge Regarding Health / Illness State	<input type="checkbox"/> Pt will demonstrate an increase in knowledge related to health / illness state	<input type="checkbox"/> Patient teaching plan initiated	q 24 hr or as indicated		
			<input type="checkbox"/> Pt will verbalize knowledge about selfcare activities				
		<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Pt will demonstrate application of health teaching into daily activities				
		<input type="checkbox"/> Discharge Planning	<input type="checkbox"/> Pt will have appropriate supportive care at time of discharge	<input type="checkbox"/> Resources Required / Date contracted:	As indicated		
			<input type="checkbox"/> Self care	<input type="checkbox"/> Social Services			
			<input type="checkbox"/> Family Care	<input type="checkbox"/> Home Care Agency:			
			<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Equipment			
			<input type="checkbox"/> Placement in long term care facility	<input type="checkbox"/> Continuity of Care Coordinator			
				<input type="checkbox"/> Assess home support system	As indicated		
				<input type="checkbox"/> Discuss patient needs at discharge planning rounds	Weekly		

PART OF THE MEDICAL RECORD

