PATIENT CARE PLAN

Name________________________ Physician________________________

Diagnosis________________________

____

Recap Date:____________ Allergies:________________________

Date of Admission____________ D.O.B.____________ Age______ Sex______ Religion____________ Rehab. Potential______

Dentures ☐ Hearing Aid ☐ Glasses ☐

	YES	NO		YES	NO
Bladder Cont.	☐	☐	Bed Rest	☐	☐
Bowel Cont.	☐	☐	W/C	☐	☐
Postural Supports	☐	☐	Ambulatory	☐	☐

W/C ☐

Bed ☐ with____________

Type ____________

Alerts: ________________________

____

____

____

EVALUATIONS:

DATE	DEPT	SIGNATURE

DATE	DEPT	SIGNATURE

LONG TERM GOAL:

DISCHARGE PLANNING STATEMENT:

Date	Prob #	Problem/Strength	Pt. Goals	Target Date	App Letter	Approach/Plan	By Whom	Initial	Date Dcd. Resvid

LAST NAME	FIRST NAME	ATTENDING PHYSICIAN	MED. REC. NO.	ROOM NO.

CM-1005A

SNF FORMS

Page ______

Date	Prob #	Problem/Strength	Pt. Goals	Target Date	App Letter	Approach/Plan	By Whom	Initial	Date Dcd. Resvid.

SNF FORMS

INITIAL	SIGNATURE

INITIAL	SIGNATURE

INITIAL	SIGNATURE

LAST NAME	FIRST NAME	ATTENDING PHYSICIAN	MED. REC. NO.	ROOM NO.

PATIENT CARE PLAN