Diagnosis: _____

Admit Date: _____ DOB _____ Sex/Age _____ ☐ Dentures _____

Recap Date: _____ Religion: _____ ☐ Hearing Aid _____

☐ Glasses _____

Allergies: _____

Alerts: _____

Evaluations

| Date | Dept. | Signature |
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Initial Identification

| Initials | Signature/Title |
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Long Term Goal: _____

Discharge Plan Statement: _____

Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
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Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
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| Last Name: | First Name: | Med. Rec. #: | Physician | Page # |
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# RESIDENT CARE PLAN



SNF FORMS

# RESIDENT CARE PLAN

Resident _____ Page # _____

Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
|---|---|---|---|---|
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Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
|---|---|---|---|---|
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Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
|---|---|---|---|---|
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Prob. # _____ Problem: _____

Goal: _____

Target Date: _____

| Date | Approach/Plan | Disc | Init | DC |
|---|---|---|---|---|
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SIT FORMS