**Hydration/Dehydration Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my diagnoses related to dehydration:** | List all diagnoses related to dehydration, or indicate if there are none. |
| **I am allergic to these things:** | List all known allergies and sensitivities, or indicate if there are none. |
| **The goal of this Healthcare Plan is:** | [ ]  I won’t show any signs of dehydration for ## days/months.[ ]  I will not experience increased heart rate for ## days/months.[ ]  Describe any other goal related to hydration/dehydration. |
| **Progress in the past year:** | What has my hydration/dehydration status for the past year been as compared with the year prior? |
| **In an EMERGENCY****Call 911 IMMEDIATELY and begin CPR if I:****🡪 Become extremely lightheaded****🡪 Lose consciousness or become unresponsive****🡪 Am confused or have a sudden change in behavior****🡪 Have gray or pale skin or blue lips****🡪 Describe any additional instructions here.** |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **When I am dehydrated, this is what usually happens:** | [ ]  I urinate less.[ ]  My urine has a dark color and/or a strong odor.[ ]  My mouth is dry.[ ]  My skin is dry and/or my lips are cracked.[ ]  I am extremely thirsty.[ ]  I am unusually tired and/or I have a hard time waking up.[ ]  I am dizzy or lightheaded or weak.[ ]  I have lost weight.[ ]  My skin lacks elasticity (for example, when pulled gently at the wrist, it takes a while to return to original position).[ ]  Other: Describe any other things that happen to me when I become dehydrated, or indicate if there are none. |
| **Supporters should be aware that some conditions and circumstances make it more likely that I will have become dehydrated:** | [ ]  I cannot tell you when I am thirsty.[ ]  I need help eating and drinking.[ ]  I take medication with a side effect of dehydration.[ ]  I have a health condition, such as diabetes or kidney disease, that makes dehydration more likely.[ ]  I sometimes refuse to eat or drink.[ ]  I drool a lot.[ ]  I frequently experience vomiting and/or diarrhea.[ ]  Other Describe any other things that make dehydration more likely, or indicate if there are none. |
| **This is how to help me remain adequately hydrated:** | [ ]  Encourage me to drink plenty of fluids during the day.[ ]  Make sure I consume ## ounces or milliliters of fluid per day.[ ]  When I am having problems getting enough to drink, offer me foods with a high fluid content such as List examples of high fluid foods appropriate for me here, or indicate if this is not applicable.[ ]  Document my fluid intake.[ ]  Monitor the color of my urine and report to nursing if my urine appears dark and/or cloudy.[ ]  Document my urine output.[ ]  Make sure that I do not eat or drink these foods/liquids: list those foods/liquids here, or indicate if there are none.[ ]  Other Describe any other supports I need to remain hydrated, or indicate if there are none. |
| **If I become dehydrated, these are the things you should do to help me:** | [ ]  Report any signs/symptoms of dehydration to the nurse as soon as you notice them.[ ]  Other Describe any other things that need to be done if I become dehydrated, or indicate if there are none. |
| **Documentation:**  | Describe where supporters should record fluid intake and any signs/symptoms of dehydration. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to dehydration, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

 RN Typed Name and Agency

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