**GERD Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my diagnoses related to GERD (reflux):** | List all diagnoses related to reflux. |
| **I am allergic to these things:** | List all known allergies and sensitivities, or note if there are none |
| **The goal of this Healthcare Plan is:** | [ ]  I will remain free of signs and symptoms of reflux for the duration of the ISP year.[ ]  I will be able to choose meals and snacks that will not increase my reflux for the duration of the ISP year.[ ]  Describe any other goal related to managing reflux. |
| **Progress in the past year:** | What is the status of my GERD this year as compared with the year prior? |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 Vomit blood****🡪 Am having trouble breathing, am wheezing, or it seems like my airway I obstructed****🡪 Lose consciousness (become unresponsive)****🡪 Describe any additional instructions here.** |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **When I have reflux, this is what usually happens**: | [ ]  I have a burning feeling in my throat, chest, or stomach.[ ]  I regurgitate stomach contents.[ ]  I have hiccups frequently.[ ]  My voice sounds more hoarse than usual.[ ]  It is painful or hard for me to swallow.[ ]  I swallow repeatedly and more than is usual.[ ]  I cough a lot.[ ]  There is blood in my feces. [ ]  I put my hand in my mouth a lot.[ ]  I drool a lot.[ ]  Other Describe any other things I do that happen to me when I experience reflux, or indicate if there are none. |
| **Supporters should be aware that some conditions and circumstances make it more likely that I will experience reflux:** | [ ]  I have a feeding tube.[ ]  I eat quickly and/or I overeat.[ ]  I have scoliosis or body alignment problems.[ ]  I cannot move around by myself very well.[ ]  I have dysphagia (difficulty swallowing).[ ]  I have gastroparesis (a condition that causes my stomach to empty too slowly or not at all).[ ]  I like to lie down soon after eating.[ ]  I have a hiatal hernia.[ ]  I am frequently constipated.[ ]  I like to drink a lot of caffeinated or carbonated drinks.[ ]  Other Describe any other things that make reflux more likely, or indicate if there are none. |
| **This is how to help me prevent or lessen the symptoms of GERD:** | [ ]  Follow the diet ordered by my doctor describe the diet here – e.g., avoid fatty foods, caffeine, etc., or indicate if there are no specific requirements.[ ]  Eat ## small meals a day.[ ]  Make sure I am correctly positioned during and after meals describe positioning e.g., upright in wheelchair during meals, or indicate if there are no requirements.[ ]  Make sure that I remain upright for ## minutes/hours after meals.[ ]  Make sure that my last meal of the day is at least 2 hours before bedtime.[ ]  Make sure that the head of my bed is elevated to ## degrees.[ ]  Make sure my food is describe consistency, e.g., chopped, pureed, or indicate if there are no specific requirements.[ ]  Make sure my liquid is prepared to describe consistency, e.g., nectar, honey, pudding, or indicate if there are no specific requirements consistency.[ ]  Help me to eat at a slow, safe pace.[ ]  Make sure I take my medications on time. List the medications I take for GERD here, or indicate if there are none.[ ]  Report signs and symptoms of GERD to the nurse.[ ]  Other Describe any other supports I need during a seizure, or indicate if there are none. |
| **Documentation:**  | Describe the things that supporters should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to GERD, 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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