**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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