**Hypertension/Hypotension Healthcare Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| **These are my cardiac diagnoses:** | List all diagnoses related to cardiac health, hypertension, and/or hypotension, or note if there are none. |
| **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:** | [ ]  My blood pressure will remain stable within a range of ##/## to ##/## for ## days/months.[ ]  Describe any other goal related to managing my hyper/hypotension.  |
| **Progress in the past year:** | What is the current status of my cardiac health, and how does it compare with a year ago? |
| **In an EMERGENCY****Call 911 IMMEDIATELY if:****🡪 I Lose consciousness (become unresponsive)****🡪 I have a systolic blood pressure reading over ## or under ##.****🡪 I have a diastolic blood pressure reading over ## or under ##.****🡪 Describe any additional instructions here** |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL** **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **This is how to support me to ensure that my blood pressure remains within a safe and healthy range:** | [ ]  Make sure I receive my medication on time. [ ]  Take my blood pressure ## times each time frame, e.g., day, week, etc.[ ]  Report to nurse any reading where systolic (top) number is greater than ## or less than ##.[ ]  Report to nurse any reading where they diastolic (bottom) number is greater than ## or less than ##.[ ]  Help me make prepare food and beverages that have low sodium. [ ]  Help me prepare and eat food that has sufficient potassium.[ ]  When I am eating out, support me in making choices that are consistent with my diet.[ ]  Make sure I drink plenty of water.[ ]  Other Describe any other supports I need to regulate my hyper/hypotension, 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 related to cardiac diagnoses, 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

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

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