**Diabetes Healthcare Plan**

| **Name:** | FirstName LastName | | | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- | --- | --- |
| **These are my diagnoses related to diabetes:** | | | List all diagnoses related to diabetes, 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:** | | | My blood sugar will remain within a range of ## and ## for the duration of the ISP year.  I will be able to choose meals and snacks appropriate for managing my blood sugar for the duration of the ISP year.  Describe any other goal for the management of my diabetes. | | |
| **Progress in the past year:** | | | What is the current status of my diabetes and related conditions, and how does this compare with a year ago? | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY if:**  **🡪 I lose consciousness (become unresponsive)**  **🡪 I have a blood sugar reading greater than ## or less than ##**  **🡪 I have dizziness, confusion, rapid pulse, shakiness, blurred vision, and/or shakiness (signs/symptoms of insulin shock)**  **🡪 I exhibit signs/symptoms of hyperglycemia, such as extreme thirst, fruity-smelling breath, excessive urination**  **🡪 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 manage my diabetes and maintain the my best health:** | | | Make sure I receive my medication on time  Check my blood sugar ## times daily, weekly using describe equipment, or indicate if NOT NEEDED  Contact the nurse for instructions for any reading below ## or above ## or indicate if NOT NEEDED  Weigh me weekly, monthly and report any weight gain or loss of ## pounds or more to the nurse.  Make sure I drink plenty of water.  Support me in following a diet that is describe diet order, e.g., low sugar, low sodium, 1,800 calorie, low carb, etc., or indicate if there are no restrictions.  Support me in attending diabetic foot care appointments every ##, months, or indicate if NOT NEEDED.  Other Describe any other supports I need to maintain optimum health related to my diabetes, or indicate Not Applicable. | | |
| **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 diabetes, 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

RN Typed Name and Agency

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

RN Typed Name and Agency

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

RN Typed Name and Agency

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

RN Typed Name and Agency