**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.** |
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| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL** **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |

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| **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[x]  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

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