**Describe Condition Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my medical diagnoses related to this condition:** | List all diagnoses related to this condition. | | |
| **I am allergic or sensitive to these things:** | List all known allergies and sensitivities. | | |
| **The goal of this Healthcare Plan is:** | I will be free of signs and symptoms of Describe Condition for the duration of the ISP year.  Describe any additional goal here. | | |
| **Progress in the past year:** | Describe the status of my health for the past year relative to this condition. | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY if I:**  **🡪 lose consciousness (become unresponsive);**  **🡪 Describe any additional instrucctions specific to this condition here.**  **🡪 Describe any additional instrucctions specific to this condition here.**  **🡪 Describe any additional instrucctions specific to this condition here.**  **🡪 Describe any additional instrucctions specific to this condition here.** | | | |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL**  **I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | |
| **These are things about me that increase my risk of health complications for this condition.** | Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields.  Describe physical characteristic, behavior, or environmental condition that increases risk. When done listing risk factors, delete remaining fields. | | |
| **These are medical diagnoses that impact this condition:** | Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields.  Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields.  Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields.  Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields.  Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields.  Describe medical diagnoses/conditions that impact this condition. When done listing diagnoses, delete remaining fields. | | |
| **These are the things I rely on supporters to help me with related to this condition:** | Describe the things supporters need to do to help me with this condition. When done listing interventions, delete remaining fields.  Describe the things supporters need to do to help me with this condition. When done listing interventions, delete remaining fields.  Describe the things supporters need to do to help me with this condition. When done listing interventions, delete remaining fields.  Describe the things supporters need to do to help me with this condition. When done listing interventions, delete remaining fields.  Describe the things supporters need to do to help me with this condition. When done listing interventions, delete remaining fields. | | |
| **Documentation:** | Describe the things 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 allergies and sensitivities, 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