**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