**Hypertension/Hypotension Healthcare Plan**

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| --- | --- | --- | --- | --- | --- |
| **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

RN Typed Name and Agency

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

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

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