**Medical Non-Compliance Healthcare Plan**

| **Name:** | FirstName LastName | | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- | --- |
| **These are my medical diagnoses with treatments/screenings where non-compliance is a problem for me:** | | List all diagnoses or conditions with treatments or screenings where non-compliance has been a problem. | | |
| **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:** | | I will be free of medical complications due to non-compliance with treatment and/or screenings for the duration of the ISP year.  I will take my medications as prescribed and follow doctor’s orders for the duration of the ISP year.  I will tolerate all exams/screenings with appropriate support for the duration of the ISP year.  Describe any other goal related to medical non-compliance. | | |
| **Progress in the past year:** | | Describe the status of my health for the past year related to medical non-compliance. | | |
| **I sometimes refuse to take medications and/or follow doctor’s orders under these circumstances:** | | I have had a change in prescribed medication or the medication delivered by the pharmacy appears different than it did in the past.  There is noise and distraction in the area where I am receiving my medications.  I do not like the way my medications make me feel.  I have side effects from my medications that I do not like.  I have difficulty safely swallowing medications.  I have a special diet ordered by my doctor, but I sometimes eat foods that are not on that diet.  Describe other problems I may have with medications or following doctor’s orders, or note if there are none | | |
| **Supporters can do these things to help me take my medications on time and as prescribed and follow doctor’s orders:** | | Talk to me about the reason for each medication I am taking.  Talk to me about side effects.  Help me talk to my doctor about how my medicine makes me feel.  Make sure that I receive my medication in the correct form (for example, crushed, mixed with food, etc.)  Make sure that I have a quiet, comfortable place to take my medication.  Have snacks that are on my diet available to me so that I can get them easily when I am hungry.  Provide choices at mealtime that are within my diet, so that if I don’t want one food, I can choose another.  Follow the instructions in my PBSP.  **Other:** Describe any other strategies to use to help me take medications/follow diet. | | |
| **I have corrective devices that I often refuse to use.** | | Glasses  Hearing aids  Dentures  Braces for my ankles and feet  Splints for my hands, wrists, elbows  **Other:** Describe any other corrective devices I have trouble tolerating. | | |
| **Supporters can do these things to help me use my corrective devices.** | | If I have a desensitization plan, follow those instructions when helping me use the device(s) specified.  Keep my device(s) near at hand in situations where they would be useful to me. For example, if I like to watch television, keep my glasses and hearing aids in the room where I watch television.  Help me talk to my doctor or appropriate specialist about any discomfort that the device is causing for me.  Support me in putting the device(s) on myself, rather than doing it for me.  Talk to me about what is going on when you are helping me put a device on.  **Other:** Describe any other strategies for helping me use corrective devices. | | |
| **I have difficulty tolerating these medical/dental examinations and/or procedures.** | | Any medical exams or screenings  Dental cleanings and exams  Dental restorative treatment (such as fillings)  Lab work (blood draws)  Pelvic Exams/Pap Smears  Mammograms  Prostate Exams  **Other**: Describe any other exams or procedures that are difficult for me, or indicate if there are none. | | |
| **These are the things I rely on supporters to do and help me do so that I can be successful with appointments.** | | Help me take an anti-anxiety or sedating medication prior to appointments (if this is prescribed by my physician).  Follow desensitization strategies written in my PBSP.  Talk to me before the appointment about what is going to happen.  During the appointment, explain what is going on, what will happen next, and how long it will last.  Schedule my appointments at a time of day when there is less likely to be a long wait.  Where IV sedation will be used, help me to follow the pre-appointment instructions.  **Other:** Describe any other strategies to help me tolerate medical/dental examinations or procedures, 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 relative to medical non-compliance, 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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