**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

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